TRANSFORM FITNESS SPORTS INJURY CENTRE CLIENT RECORD CARD

Name: _____ **Date:** ____ / ____ / ____

Address: _____

_____

Clinic: _____ **Therapist:** _____

DOB: __ / __ / __ **Contact Number/Email:** _____

Site of Injury: _____ **Date of Injury:** __ / __ / __ **Sport(s):** _____

Referred by: Self GP Physio

Other Doctor: _____ **Address:** _____

Medical History *please circle yes or no*

Constant Pain yes no	**Disturbed Sleep** yes no	**Blood Pressure** yes no	**Lung Conditions** yes no	**Anticoagulants** yes no
Previous cancer yes no	**Steroids** yes no	**Weight Loss** yes no	**Heart Conditions** yes no	**HIV / Hepatitis** yes no
Diabetes yes no	**Epilepsy** yes no	**Asthma** yes no		

Medication: _____

Previous Injury History: _____

Current History: _____

Body Chart: *(document problem area(s) +/- referred symptoms, pain scale, aggravating/easing factors, constant/intermittent, deep/superficial, swelling, scars, pins and needles, paresthesia, numbness, and structural deformities)*