Initial consultation / new injury questionnaire

Player name: __________________________ Sex: □ Male □ Female Age: _______

Diagnosis of condition / reason for this consultation: ____________________________

Injury type: (please ✚ one box)
□ Bone □ Joint □ Muscle □ Tendon □ Contusion □ Laceration
□ Central/peripheral nervous system □ Other: ____________________________

Reason for Presentation (please ✚ one box)
□ New injury – player has not previously had this type of injury
□ Aggravation or exacerbation of a current existing injury that had not fully resolved
□ Recurrence of a previous injury that had that had fully resolved (i.e. was pain free)
□ Maintenance / preventative / asymptomatic care
□ Illness
□ Other ____________________________

How long has the player had this condition or pain for: (please ✚ one box)
□ 0-7 days □ 1-4 wks □ 1-3 mths □ 3-6 mths □ 6-12 mths □ 1-2 yrs □ 2+ yrs

Please rate the degree of pain the player has for this condition: (circle one number)
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Mechanism of injury: how did the injury occur? (please ✚ one box)
□ Contact / physical collision with another player or object. Specify __________________
□ Non-contact / DID NOT involve physical contact. Specify __________________
□ Uncertain / the injury gradually developed. Specify __________________

Type of activity at time of injury (please ✚ one box)
□ Competition. Specify period of game: □ First □ Second □ Third
□ Training/practice
□ Other ____________________________

If applicable, did the player have to stop playing or training because of injury?
□ Yes □ No

If no, was the player restricted or limited from full participation? □ Yes □ No

What other practitioners has the player previously consulted for this condition:
(please ✚)
□ None □ Medical doctor □ Physiotherapist □ Massage therapist / Myotherapist
□ Chiropractor □ Osteopath □ Other: ____________________________

Was referral for advanced imaging required? (please ✚)
□ No □ Yes. Specify: □ x-ray □ CT/MRI □ Ultrasound □ Other ________________

Was referral to another health care provider required? (please ✚)
□ No □ Yes. Specify □ Medical doctor □ Ambulance □ Hospital □ Physio
□ Other: __________________

If applicable, was this provided at the event? (please ✚)
□ No □ Yes