mch Medical Center Hospital

your hospital your choice

Sports Injury Evaluation Form

Athlete Information

Name ____________________ Date of Birth ____________ Age ______

Address ____ SS#______________

Street City State Zip

Phone ____________________ Parent/Guardian Name ____________________

School ____________________ Trainer/Coach Name ____________________

Injury Information

Location of Injury ____________________ Date of Injury ____________ Re-injury? **Y N**

Pain Level-(scale of 1-10)_____ Medications-(list, presently taking)-____________________

Mechanism of Injury *(Briefly describe how the injury occurred)*

____

____

Previous History of Injury *(List other injuries which required medical attention)*

____

____

Physician Evaluation

Eval:

Impression:

Plan:

<u>**Return to**</u>**: Saturday Clinic Treating Physician Office Other** ____________________

In: ***ASAP 1 2 weeks*** ____________

(circle as needed) XRAY MRI PT OT DME_________ REFERRAL______________

______________________________ Physician

______________________________ Date

Medical Center Hospital /Sports Medicine

P.O. Box 7239, Odessa, Texas 79760 Phone 432 640.1230 FAX 432 640.2235