AT DIRECT SPORTS MEDICINE, LLC

New Patient Paperwork

Patient Name: _____ DOB:_____ M/F:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Grad Year:_____ Date of Last Physical if known: _____

Height:_____ft_____in Weight:_____lbs Blood pressure:_____/_____R/L Pulse:_____bpm

Guardian/Emergency Contact:

Patient Name: _____DOB:_____ Relation:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

General Info: Please check one

- Are you currently taking any prescription or over-the-counter medicines and supplements (herbal and nutritional)? ☐YES ☐NO
- Do you have any allergies? ☐YES ☐NO
- Has a doctor ever denied or restricted your participation in sports for any reason? ☐YES ☐NO
- Do you have any ongoing medical conditions? ☐YES ☐NO
- Have you ever spent the night in hospital? ☐YES ☐NO
- Have you ever had surgery? ☐YES ☐NO

Please explain any yes answers:

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Heart Health: Please check one

- Have you ever passed out or nearly passed out DURING or AFTER exercise? ☐YES ☐NO
- Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? ☐YES ☐NO
- Does your heart ever race or skip beats (irregular beats) during exercise? ☐YES ☐NO

- Has a doctor ever told you that you have any heart problems? ☐YES ☐NO
- Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) ☐YES ☐NO
- Do you get lightheaded or feel more short of breath than expected during exercise? ☐YES ☐NO
- Have you ever had an unexplained seizure? ☐YES ☐NO
- Do you get more tired or short of breath more quickly than your friends during exercise? ☐YES ☐NO
- Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before 50 (including drowning unexplained car accident, or sudden infant death syndrome)? ☐YES ☐NO
- Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? ☐YES ☐NO
- Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? ☐YES ☐NO
- Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? ☐YES ☐NO

Please explain any yes answers:

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Bone and Joint: Please check one

- Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? ☐YES ☐NO
- Have you ever had any broken or fractured bones or dislocated joints? ☐YES ☐NO
- Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? ☐YES ☐NO
- Have you ever had a stress fracture? ☐YES ☐NO
- Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) ☐YES ☐NO
- Do you regularly use a brace, orthotics, or other assistive device? ☐YES ☐NO
- Do you have a bone, muscle, or joint injury that bothers you? ☐YES ☐NO
- Do any of your joints become painful, swollen, feel warm, or look red? ☐YES ☐NO
- Do you have any history of juvenile arthritis or connective tissue disease? ☐YES ☐NO

Please explain any yes answers:

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Medical Questions Please check one

• Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐YES	☐NO
• Have you ever used an inhaler or taken asthma medicine?	☐YES	☐NO
• Is there anyone in your family who has asthma?	☐YES	☐NO
• Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐YES	☐NO
• Do you have groin pain or a painful bulge or hernia in the groin area?	☐YES	☐NO
• Have you had infectious mononucleosis (mono) within the last month?	☐YES	☐NO
• Do you have any rashes, pressure sores, or other skin problems?	☐YES	☐NO
• Have you had a herpes or MRSA skin infection?	☐YES	☐NO
• Have you ever had a head injury or concussion?	☐YES	☐NO
• Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	☐YES	☐NO
• Do you have a history of seizure disorder?	☐YES	☐NO
• Do you have headaches with exercise?	☐YES	☐NO
• Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐YES	☐NO
• Have you ever been unable to move your arms or legs after being hit or falling?	☐YES	☐NO
• Have you ever become ill while exercising in the heat?	☐YES	☐NO
• Do you get frequent muscle cramps when exercising?	☐YES	☐NO
• Do you or someone in your family have sickle cell trait or disease?	☐YES	☐NO
• Have you had any problems with your eyes or vision?	☐YES	☐NO
• Have you had any eye injuries?	☐YES	☐NO
• Do you wear glasses or contact lenses?	☐YES	☐NO
• Do you wear protective eyewear, such as goggles or a face shield?	☐YES	☐NO
• Do you worry about your weight?	☐YES	☐NO
• Are you trying to or has anyone recommended that you gain or lose weight?	☐YES	☐NO
• Are you on a special diet or do you avoid certain types of foods?	☐YES	☐NO
• Have you ever had an eating disorder?	☐YES	☐NO
• Do you have any concerns that you would like to discuss with a doctor?	☐YES	☐NO

Please explain any yes answers:

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I, as parent or guardian of the student identified above, hereby grant permission to any athletic trainer employed by AT Direct Sports Medicine to provide such treatment within the scope of professional services authorized for such trainer as deemed necessary for a physical condition arising during or affecting participation in such event. I acknowledge and agree that any such trainer may use his or her own judgment in securing medical aid, including ambulance and other emergency services as a result of any injury. I specifically consent and agree that AT Direct Sports Medicine may provide preventative care and treatment of athletic injuries and rehabilitation and reconditioning of athletic injuries.

I, as, the or guardian hereby authorize the physician(s), athletic trainer(s) and/or sports medicine staff representing AT Direct Sports Medicine to gather and release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's preparation for and participation in athletics at AT Direct Sports Medicine**.** I/We further authorize the physician(s), athletic trainer(s), and/or sports medicine staff representing AT Direct Sports Medicine to inquire on and receive the student-athlete's protected health information from other medical personnel as it relates to his/her care by the sports medicine staff at AT Direct Sports Medicine**.**

This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related individually identifiable health information. This protected health information may be released to other healthcare providers, hospitals and/or medical clinics and laboratories, athletic trainers, athletic coaches, medical insurance coordinators athletic and/or school administrators and officials of the state's high school athletic association.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student athlete's protected health information may be a condition for the student-athlete's participation in interscholastic sports at the School. I understand that the student-athlete's protected health information is protected under Federal law. I, the parent/legal guardian, understand that once information is disclosed per this authorization, the information is subject to re-disclosure by the recipient and may no longer be protected under federal law. I may revoke this authorization at any time by notifying the school's athletic director in writing, but if I do, it will not have any effect on actions taken in reliance of my prior authorization. This authorization expires one year and ninety days from the date it is signed.

By signing below, I agree and acknowledge that AT Direct Sports Medicine employees certified, licensed athletic trainers who are under the direct care of a overseeing physician and practice within their specified scope.

Patient/Parent Name:_____

Patient/Parent Signature:_____

Cancellation Policy

I understand that if I fail to communicate to AT Direct Sports Medicine more than 24 hours in advance, I will occur a $30 cancellation fee.

Patient/Parent Name:_____

Patient/Parent Signature:_____

Payment

I understand that payment is due at the time of treatment unless previous payment is provided.

Patient/Parent Name:_____

Patient/Parent Signature:_____