Personal History Today's Date: ____/____/_____

Name: _____ Date of Birth: ____/____/_____
Club or High School Team Name: _____ Yr or Level: _____
hours / week in gym: _____ Height/Weight: _____/_____
of years in gymnastics: _____ Age of first period: _____

Current Injury and brief history of how it happened: _____
_____
_____

Is this a reinjury? ☐ Yes ☐ No
If Yes, when did the original injury occur? _____

Questionnaire

Please list all injuries that have held you out of gymnastics for longer than one week: ___
_____
_____
_____
_____
_____

Please list all orthopedic surgeries (bone or joint only): _____
_____
_____
_____

For your current injury, what skills or movements are the most painful? Check all.
☐ Bending back ☐ Twisting ☐ Weight bearing
☐ Bending forward ☐ Running/Jumping ☐ Other: _____
_____
_____

Do you wear braces when doing gymnastics? ☐ Yes ☐ No
☐ Tiger Paws (floor/vault)
☐ Ankle braces
☐ Knee braces

Have you done Physical Therapy for your current injury? ☐ Yes ☐ No
If so, where: _____

Have you had a recent growth spurt? ☐ Yes ☐ No

Office Use Only

Imaging:

Skeletal Maturity: ☐ Yes ☐ No

☐ Powerful ☐ Graceful

Ligamentous Laxity Scale:

Diagnosis:

Recommended Treatment:

☐ No participation	☐ Modified Activities	☐ Full as tolerated
☐ MRI	☐ CT Scan	☐ Bracing: _____
☐ Casting	☐ Therapy	☐ Other: _____

_____

_____

Overall time loss for injury: _____

_____

_____