# Golf Assessment

## GENERAL INFORMATION

Date:_____ How did you hear of us? _____Name?_____

Name: Last:_____ First:_____ M.I.:_____

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

Age: _____ Gender: _____ Marital Status: _____ Occupation: _____

Date of Birth:____/_____/_____

Phone: Home:_____ Work:_____

Other:_____ E-Mail:_____@_____

Emergency Contact Name:_____ Phone:_____

Physician Name: _____

Address: _____

_____

Phone: _____

## MEDICAL HISTORY

General Health (check one): ___Excellent ___Good ___Fair ___Poor

Have you had any **medical problems** or hospitalizing in the past year (circle)? Yes No

If "yes", please specify: 1._____

2._____

3._____

Surgical History: Procedure:_____Date:_____

Procedure:_____Date:_____

Prescriptions Medications: _____

Over-the-counter Medications: _____

Tobacco Yes No If yes, please specify ppd: _____ years: _____

Alcohol (circle): Yes No If yes, please specify: amount/day, week, or month: _____

Caffeine Yes No # drinks/day _____

**PAST INJURY/PROBLEM HISTORY**

| Date | Injury/Problem | Whom Seen | Treatment | Recovery Time |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

**Present Injuries/Problems (if applicable):**

Date of Injury/Onset:_____ Body Part(s):_____

Mechanism of Injury/Onset:_____

_____

Type of Onset (check one): ____Gradual ____Sudden

Symptoms at the time of onset:_____

_____

Current symptoms (**aggravate/relieve**): _____

_____

_____

_____

_____

**Present/past medical conditions (circle):**

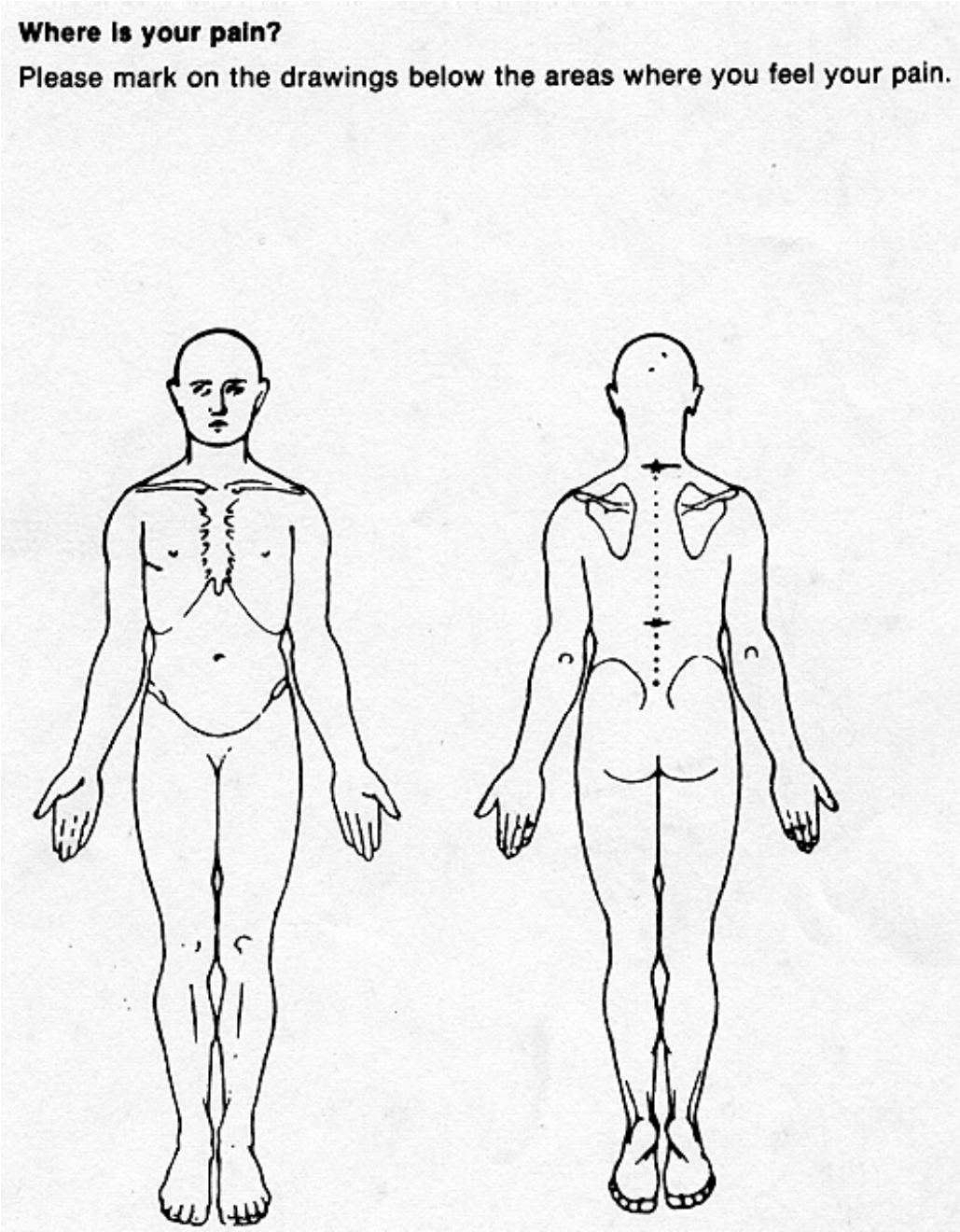
| | | | | | |
|---|---|---|---|---|---|
| Asthma | Y | N | Heart Attack | Y | N |
| Arthritis | Y | N | Heart Disease | Y | N |
| Cancer | Y | N | Hernia | Y | N |
| Chemical Dependency | Y | N | High Blood Pressure | Y | N |
| Circulatory Disease | Y | N | Kidney Disease | Y | N |
| Depression | Y | N | Metal/other implant | Y | N |
| Diabetes | Y | N | Multiple sclerosis | Y | N |
| Dizziness | Y | N | Nervous Disorder | Y | N |
| Eating Disorder | Y | N | Numbness | Y | N |
| Emphysema | Y | N | Osteoporosis | Y | N |
| Epilepsy | Y | N | Pregnancy | Y | N |
| Fainting | Y | N | Stroke | Y | N |
| Fatigue | Y | N | Thyroid Problems | Y | N |
| Headaches | Y | N | Tuberculosis | Y | N |
| Hepatitis | Y | N | Weakness | Y | N |
| Fever/chills/sweats | Y | N | Night pain | Y | N |
| Unexplained weight change | Y | N | Dyspnea | Y | N |
| Nausea/vomiting | Y | N | Dysuria | Y | N |
| Bowel dysfunction | Y | N | Sexual dysfunction | Y | N |
| Urinary frequency changes | Y | N | | | |

Comments: _____

Has any one in your immediate family been treated for any of the conditions listed on the previous page? If yes, please specify:

_____

If you experience pain as a result of your golfing, please indicate the location below:




**GOLF BACKGROUND**

1. How often do you golf?

2. What are your current recreational/fitness activities?

3. What are your goals for this assessment?