Parallel Physical Therapy & Wellness

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Gymnast Intake Form

Name: _____ Date of Birth: _____ Age: _____

Pronouns: _____ Sex Assigned at Birth: _____ Current Gender Identity: _____

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

Home Phone: _____ Cell Phone: _____ E-mail: _____

Emergency Contact 1 Name:_____ Relationship to you: _____

Emergency Contact 1 Phone: _____ E-mail: _____

Emergency Contact 2 Name:_____ Relationship to you: _____

Emergency Contact 2 Phone: _____ E-mail: _____

Problem:_____ Right ___ Left___ Onset Date:_____

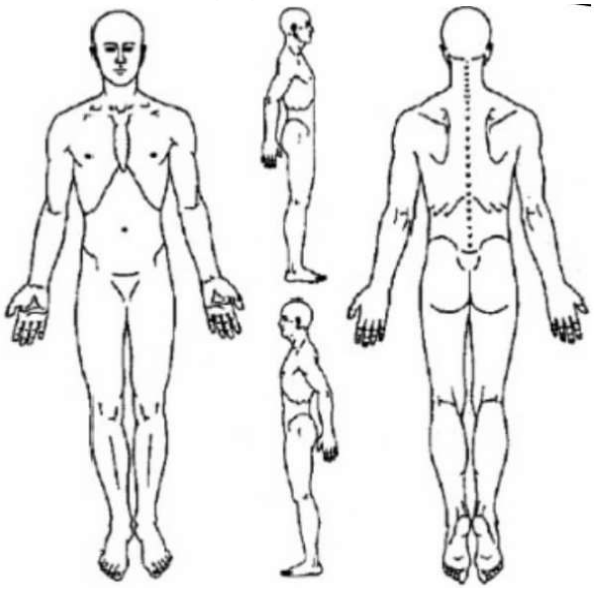
How did Symptoms Start? _____ Have you experienced these symptoms before? Y / N

Date of Surgery/Pending Surgery:_____ Procedure:_____

Imaging/Dates for this Issue: X-Ray:_____ MRI:_____ CT Scan:_____ Ultrasound:_____ Other:_____

Pain at Worst (circle one): 0 1 2 3 4 5 6 7 8 9 10
Pain at Best (circle one): 0 1 2 3 4 5 6 7 8 9 10
Pain Currently (circle one): 0 1 2 3 4 5 6 7 8 9 10

Indicate Symptom Location Below:



Pain is (circle one): Constant Comes/Goes Only with Activity
Pain is (circle one): Getting Better Getting Worse Not Changing
Pain Description (circle all that apply): Numbness Pins & Needles
Sharp / Stabbing Shooting Dull / Achy Burning Throbbing

Which Gymnastics Events & Activities Increase Your Symptoms?

___ Beam ___ Bars ___ Vault ___ Floor ___ Pommel Horse

___ Rings ___ Rhythmic Gymnastics ___ Front walkovers

___ Back walkovers ___ Back handsprings ___ Dismounts

___ Other (Please Specify): _____

Other Activities That Increase Symptoms: ___ Sitting ___ Standing ___ Walking ___ Stairs ___ Running

___ Squatting ___ Bending ___ Reaching ___ Driving ___ Lifting ___ Kneeling ___ Gripping/Grabbing

___ Other (Please Specify): _____

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Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Job/Occupation: _____ Work Demands: _____

Exercise/Hobbies/Activities: _____

Current/Past PT/OT/Chiro/Massage? _____

Please circle any/all of the following problems you have or have had in the past:

Asthma/Breathing Problems	Alcohol/Drug Abuse	Arthritis	Alzheimer's or Dementia
Bowel/Bladder Problems	Bleeding Disorders/Blood Thinners	Chest Pain	Cancer
Cerebral Palsy	Circulatory Problems/Blood Clots	COPD/Emphysema	Diabetes
Depression or Anxiety	Dizziness/Fainting	Eating Disorders	Fractures (Broken Bones)
Headaches	Heart Attack/Heart Disease	Hernia	High Blood Pressure
High Cholesterol	Hepatitis	Infectious Disease	Irregular Periods
Kidney Problems	Liver/Gallbladder Problems	Multiple Sclerosis	Nausea/Vomiting
Osteoporosis or Osteopenia	Pregnancy (current or possible)	Parkinson's Disease	Pacemaker
Seizures/Epilepsy	Special Diet Guidelines	Skin Abnormalities	Sexual Dysfunction
Stomach Issues/GERD	Stroke	Tobacco Use	Urine Leakage

Other (Please Specify): _____

_____

Any Allergies (Please List)? _____

Are you currently Menstruating? ___ Y ___ N Are your periods regular? ___ Y ___ N

Please list any and all past surgeries (including dates): _____

_____

_____

_____

Please list any and all Medications: _____

_____

_____

_____

What is your goal for Physical Therapy? _____

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Weekly Schedule - Gymnast

Occupation: _____ School/Work Name: _____ Training Gym/School: _____

Events: ___ Floor ___ Vault ___ Bars ___ Beam ___ Pommel Horse ___ Rings ___ Rhythmic

Current Level of Training: _____ Number of Years of Experience: _____

Gymnastics is: ___ Fun/Recreational ___ Goal for High School ___ Goal for Nationals ___ Goal for College ___ Goal for Olympics

Other Exercise/Hobbies/Activities: _____

Please fill in the below chart with your typical weekly schedule. This will help us to better understand your daily routines. Items to include: Approximate wake and sleep times, school/work hours, training hours and events performed each day, other exercises/hobbies/activities.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Wake Time: _____	Wake Time: _____	Wake Time: _____	Wake Time: _____	Wake Time: _____	Wake Time: _____	Wake Time: _____
Sleep Time: _____	Sleep Time: _____	Sleep Time: _____	Sleep Time: _____	Sleep Time: _____	Sleep Time: _____	Sleep Time: _____