UW-Milwaukee Performance and Injury Center
Rehabilitation and Injury Screening Form

Please complete this form as completely as you can and email it back to Lori Woodburn at woodburn@uwm.edu or bring it with you to the appointment. The center team will review this form with you at your first appointment

Name:_____Age:_____ Date: _____

1. Circle events you currently participate in or have completed:
   a. Cycling: Road Track Mountain
   b. Running: 5K 10K ½ marathon Marathon Ultra
   c. Triathlon: Sprint Olympic ½ Ironman Ironman
   d. Nordic Skiing: Skating Classic

2. How many years have you been participating in your sport/s? _____

3. Average weekly training routine (include mileage, speed, distance, or time):
   a. Cycling _____
   b. Running_____
   c. Swimming _____
   d. Weight training_____
   e. Stretching _____
   f. Warm-up/cool-down_____
   g. Other exercise(other sports, yoga, pilates, dance, martial arts, etc)
      _____

4. Are you currently experiencing pain with training? YES NO

5. If yes, describe your current injury
   a. When did it begin?
   b. How did it happen?
   c. Where is your pain located?
   d. What have you done to treat the injury?
   e. Is it getting BETTER / SAME / WORSE ? (circle one)

6. Please check any of the following that you have had in the past, or are currently experiencing (We will talk with you personally about any injuries that you check YES)

Yes	No	Injury	Date of Injury and current status (to be completed by clinic staff)
		Concussion or traumatic brain injury	
		Neck pain	
		Back pain	
		Disc herniation	
		Shoulder pain (right – left)	
		Groin pain (right – left)	
		Hip pain or injury (right – left)	
		Iliotibial band syndrome (right – left)	Knee or hip pain?
		Hamstring injury (right – left)	
		Knee pain or injury (right – left)	
		Shin splints (right – left)	
		Ankle sprain (right – left)	
		Plantar fasciitis (right – left)	
		Achilles tendonitis (right – left)	
		Other foot pain or injury (right – left)	
		Fractures (location of fractures?)	
		Briefly describe any other injuries	

7. Do you have any of the following medical conditions?
    a. Asthma or respiratory disease
    b. Diabetes
    c. Cardiovascular disease
    d. High blood pressure
    e. Depression or anxiety
    f. Other_____

8. Have you had any surgeries? YES NO
    a. If yes, briefly describe

9. List any over-the-counter or prescription medications that you are currently taking

10. Do you wear orthotics? _____Yes _____No
    (If yes, please bring them to your appointment)

11. How often do you replace your shoes? _____months _____miles

12. Do you use any sports drinks, gels, bars, or other sports products during training or competition? If so, please elaborate.

13. Do you drink fluids on a schedule while training? If so, please describe your hydration routine.

14. Do you have any specific nutrition-related concerns? If so, please list.

15. Are there any specific training concerns you wish to discuss with clinic staff?

For clinic use only:
Form reviewed and discussed with participant by:

_____ Date:_____
Signature and Credentials

_____ Date:_____
Signature and Credentials

_____ Date:_____
Signature and Credentials

_____ Date:_____
Signature and Credentials

_____ Date:_____
Supervising Clinician Signature and Credentials