BLACK AND BLUE CLINIC

Proud to Partner with ACHS & ACMS

Patient Name:_____Date:_____ D.O.B : _____

Sport(s):_____Currently participating: Y ◯ N ◯

Problem:_____

Date of Injury:_____

Primary Care Physician:_____ Insurance: _____

Parent/Guardian Name:_____

Telephone:_____ Email:_____

Schuster Physical Therapy Patient Informed Consent:

I voluntarily consent to a physical therapy screening and services. I acknowledge that no guarantees have been made to me as to the results of the PT screening at Schuster Physical Therapy. It is this clinic's sincere intent to educate me on every process. If techniques that are being used or are planned to be used to address my symptoms are not understood fully or if I have any other questions or concerns about my care, I understand that it is my sole responsibility to communicate with my therapist or Schuster Physical Therapy.

Parent/Guardian Signature:_____Date: _____

SCREEN

(For therapist completion)

Specific mechanism of injury:_____

_____

_____

UE ROM - WNL / WFL / Limited:
LE ROM - WNL / WFL / Limited:
Spinal ROM - WNL / WFL / Limited
UE strength - Symmetrical / Asymmetrical:
LE strength - Symmetrical / Asymmetrical:

Special Testing:

_____
_____
_____
_____

Recommendations:

- ◯ Continue Sport
- ◯ Rest:_____
- ◯ Physical Therapy
- ◯ See Orthopedic Specialist
- ◯ See Primary care provider
- ◯ Other:_____

Therapist Signature

_____**Date**_____

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