

Student   
 ID#   
 Name of SAT

## Injury Details

Date of Inj.   
 Injured Area   
 Injury Type

**Activity:**

Activity Type	Activity Level	Activity	Gender	Season
<input type="text" value="Athletic"/>	<input type="text" value="Junior Varsity"/>	<input type="text" value="Track"/>	<input type="text" value="Boys"/>	<input type="text" value="2001 Spring"/>

**History:**

Explain

<input type="checkbox"/> Previous injury?	<input type="text"/>
<input type="checkbox"/> Did student hear sound?	<input type="text"/>
What was the mechanism?	<input type="text" value="tripped during race"/>
When did injury occur?	<input type="text"/>
<input type="checkbox"/> Has student seen a doctor?	<input type="text"/>
<input type="checkbox"/> Chronic problem (how long)?	<input type="text"/>

**Observations:**

How Much/Explain	How Much/Explain	How Much/Explain
<input checked="" type="checkbox"/> Swelling <input type="text"/>	<input type="checkbox"/> Vomiting <input type="text"/>	<input type="checkbox"/> Speech-type <input type="text"/>
<input type="checkbox"/> Gaps <input type="text"/>	<input type="checkbox"/> Ecchymosis <input type="text"/>	<input type="checkbox"/> Redness <input type="text"/>
<input type="checkbox"/> Eye color <input type="text"/>	<input type="checkbox"/> Guarding <input type="text"/>	<input type="checkbox"/> Dizziness <input type="text"/>
<input type="checkbox"/> Breathing <input type="text"/>	<input type="checkbox"/> Skin color <input type="text"/>	<input checked="" type="checkbox"/> Gait pattern <input type="text" value="severe limp"/>
<input type="checkbox"/> Deformity <input type="text"/>	<input type="checkbox"/> Bal./coord. <input type="text"/>	<input type="checkbox"/> Nausea <input type="text"/>
<input type="checkbox"/> Headache <input type="text"/>	<input type="checkbox"/> False mvmt <input type="text"/>	<input type="checkbox"/> Other <input type="text"/>

**Palpation (bilaterally) / Other symptoms:**

Where is it point tenderness?

<input type="checkbox"/> Laxity	<input type="checkbox"/> Crepitus	<input type="checkbox"/> Deformity
<input checked="" type="checkbox"/> Pain	<input type="checkbox"/> Skin Temp.	<input type="checkbox"/> Gapping
<input type="checkbox"/> Popping/Clicking	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other 1
<input type="checkbox"/> Heat	<input type="checkbox"/> Cap. Refill	<input type="checkbox"/> Other 2

**Special Tests:**

Stress tests	<input type="text"/>
ROM tests	<input type="text"/>
MM tests	<input type="text"/>
Laxity (degree)	<input type="text"/>
Gapping/Weakness	<input type="text"/>
Other tests	<input type="text"/>

**Vital Signs:**

BP <input type="text"/>	Color/Mvmt. <input type="text"/>	Mvmt. <input type="text"/>	Eye <input type="text"/>
Pulse <input type="text"/>	Skin Color <input type="text"/>	Pupils <input type="text"/>	
Sensory <input type="text"/>	Resp. <input type="text"/>	Temp <input type="text"/>	

**Other:**

Contact (who)? <input type="text"/>	Med. Referral <input type="text" value="None"/>
Evaluation <input type="text" value="minor strain of"/>	Treatment <input type="text" value="wrap, icepack"/>
Prognosis <input type="text" value="OK if avoid painful activities for 2 days."/>	Outcome <input type="text" value="OK on checkup 4 days later"/>