

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 mvmnt	<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/Mvmnt. <input type="text"/>	Mvmnt. <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"/>