HARKNESS CENTER *for Dance Injuries*

HARKNESS CENTER FOR DANCE INJURIES: PREVENTATIVE SCREENING FORM

Personal History:

- Name: _____Date of Birth: _____
  (mo) / (day) / (year)

- Address: _____Sex: M / F
  (street / apartment # / city / state / zip code)

- Race:
  _____African/American
  _____Asian
  _____Caucasian
  _____Hispanic
  _____Other (_____)

  Marital Status:
  _____Married
  _____Single
  _____Separated
  _____Divorced
  _____Widowed

- School/Company where you primarily study or perform: _____

- Phone (home):_____ (work or voice mail): _____
  (fax): _____ (e-mail): _____

- How did you hear about our free dance injury prevention clinic?
  _____

- Type of dance you mainly study:
  _____ballet
  _____jazz
  _____other
  _____modern*

  Current level of training:
  _____professional
  _____choreographer
  _____teacher
  _____student

*(*if you mainly study modern dance, identify the type of modern technique you study most often*) _____
_____

- continued -

- How many hours of class do you take in a typical day? _____
- How many hours of rehearsal do you have in a typical week? _____
- How many performance weeks do you have in a typical year?_____
- Do you have another job(s) to subsidize your dance life? **Yes/ No**
  If yes, describe what that job(s) is: _____
- At what age did you begin serious dance training? _____
- Do you do any other form of exercise on a regular basis? (Circle one): ***Yes / No***
  If yes, describe that exercise (see below):

Type of exercise (example, weight lifting, aerobics, Pilates, yoga, running, swimming, bicycling): _____

_____

Frequency (# time per week you do this other exercise): _____times per week

Intensity On a scale of 1-10, [1=very easy & 10=hardest exercise possible] how hard is your exercise program for you to do?: Circle one choice: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Duration (how long [per session] do you typically exercise)? _____minutes per session

- Do you train en pointe: ***Yes / No***

If yes:
At what age did you begin pointe work? _____ years old

How many hours per day do you typically spend working en pointe? _____ hours per day

- Are you currently on any medication (including aspirin or Advil-type anti-inflammatory)? **Yes / No**

If yes:
What medication, how often, in what dose?_____

For what condition? _____

What medical problems run in your family?:_____

_____

- Do you smoke? **Yes / No**

If yes:
How often / How much / For how long? _____

- *continued* -

Do you drink alcohol? **Yes / No**
If yes:
How often / How much / For how long?

- Have you ever had surgery? **Yes / No**

If yes:
What type of surgery, where and when? _____

- Have you ever been hospitalized? **Yes / No**

If yes:
Why and for how long? _____

- Do you have any of the following medical conditions?:

_____headaches / nausea / vomiting
_____contact lenses or glasses

_____seizures
_____hearing aids or dentures

_____history of cancer
_____chronic cough

_____Fever / Night Sweats
_____Pain (describe): _____

_____dizziness / fainting
_____other: _____

_____Diabetes: **Yes / No**
If yes, do you take insulin? **Yes / No**

- How much do you currently weigh? _____ pounds. How tall are you? _____feet & inches

- How long have you weighed this much? _____ At what age did you achieve this weight?_____

- At what age did you achieve this height?_____

- Is your weight stable or does it fluctuate a lot? Circle one: **Stable / Fluctuates a lot**

- Do you diet to maintain your weight?: **Yes / No**

If yes:
Describe your diet technique:_____

- About how many calories do you think you eat in a typical day?_____

- Generally, do you feel you eat well? **Yes / No** Do you take vitamin supplements? **Yes / No**

- Generally, do you feel you sleep well and you sleep enough? **Yes / No**

If no, explain: _____

- continued -

- Do you take calcium supplements? _____

- Are you satisfied with your body weight?: **Yes / No**

If no: what weight would you prefer to be? _____pounds

- What type of dance shoes do you most often train in?:

_____none (barefoot) _____jazz oxfords

_____ballet slippers _____pointe shoes

_____ character shoes _____other: _____

- Do you wear orthotics in your shoes? **Yes / No**

If yes, what type and for how long? _____

If yes, do you wear them: Circle one: In all shoes / In dance shoes only / In street shoes only

- Do you dance on sprung wood floors?: Circle one: Always / Usually / Often / Sometimes / Rarely / Never

- Do you warm-up before class?: Circle one: Always / Usually / Often / Sometimes / Rarely / Never

- What does your warm-up consist of? _____

- Do you *stretch* **after** class or exercise? Circle one: Always / Usually / Often / Sometimes / Rarely / Never

WOMEN:

- At what age did you get your menstrual period? _____years old

- Is your period regular, i.e. do you get it every 28-35 days?: **Yes / No**

- Has it always been regular? **Yes / No**

If no to either of the above questions:

- Describe your cycle: _____

- Do you go to your gynecologist every 6 -12 months for a general check-up? **Yes / No**

- When did this "not regular" pattern begin? _____years old

- Do you take oral contraceptive (i.e. "the pill")? **Yes / No**

MEN:

- At what age did you first get facial hair (i.e. a beard)? _____years old

- continued -

Medical Complaint

- What is the injury / problem you are here for today?

    a. Part(s) of body: _____

    b. How did this injury/problem happen? Circle one: **Traumatic Accident / Slow Onset**

    c. What are your current symptoms?: _____

    _____

    _____

    d. How long have you had this problem? _____years / month / weeks / days

    e. Have you had this same problem before? **Yes / No**
    If yes:
    When, how long did it last, and what made it better?_____

    _____

    f. Have you had physical therapy or other medical treatment of any kind for this problem?
    Yes / No
    If yes:
    Describe treatment: _____

    _____

    g. Did you get better? **Yes / No**

    h. What other injuries / problems have you had in the past?:_____

    _____

    i. **What do you hope to get out of today's visit? _____

    _____

    _____

    _____

HARKNESS CENTER *for Dance Injuries*

NYU Medical Center NYU**Hospital for Joint Diseases**

INJURY PREVENTION ASSESSMENT
CONSENT FOR EVALUATION

I authorize NYU Hospital for Joint Diseases and (name/s) _____
the physical therapists and/or athletic trainers in charge of the injury prevention assessment of

Name: _____

to administer orthopaedic screening tests, which may include: postural assessment, manual muscle testing, flexibility testing, functional testing and to recommend exercise or other follow-up referrals for the prevention of injuries and/or for general wellness guidelines in the assessment of this voluntary, injury-prevention assessment participant. I have read and fully understand the above consent, and all of my questions have been answered. All blanks or statements requiring insertion or completion were filled in before I signed.

Participant's signature: _____ Date: _____

If participant is a minor complete the following:
Participant (is a minor _____ years of age)

Print Name of Parent or Guardian:_____

Signature: _____ Date: _____