Amateur Baseball Screening Database

Injury Survey

Name: _____ **Date of Birth:** _____ **Today's Date** _____
Throwing Arm: Right handed__ Left handed__
Team: Freshman __ JV__ Varsity__

Current Arm Pain

1. Do you currently have pain in your throwing arm?

   ❍ **Yes** ❍ **No**

   If yes, where was the pain located?

   ❍ **Elbow** ❍ **Shoulder** ❍ **Other**_____

2. How long have you had this pain? _____
3. Are you currently seeing a doctor for this pain?

   ❍ **Yes** ❍ **No**

4. Are you currently receiving treatment for this pain?

   ❍ **Yes** ❍ **No**

   If yes, what kind of treatment?

   ❍ **Ice** ❍ **Medications** ❍ **Physical Therapy** ❍ **Injection**

   ❍ **Surgery**

History of Arm Pain

5. Have you *ever* seen a doctor for pain in your throwing arm?

   ❍ **Yes** ❍ **No**

6. Have you *ever* received treatment for arm pain in your throwing arm?

   ❍ **Yes** ❍ **No**

   If yes, what kind of treatment?

   ❍ **Ice** ❍ **Medications** ❍ **Physical Therapy** ❍ **Injection**

   ❍ **Surgery**

7. Did you *ever* miss practice(s) last season due to arm pain or injury?

   ❍ **Yes** ❍ **No**

8. Did you *ever* miss game(s) last season due to arm pain or injury?

   ❍ **Yes** ❍ **No**

9. Have you *ever* experienced arm pain while you were pitching?

   ❍ **Yes** ❍ **No**

   If yes, where was the pain located?

   ❍ **Elbow** ❍ **Shoulder** ❍ **Other**_____

   Did you continue pitching?

   ❍ **Yes** ❍ **No**

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Injury Survey

Please complete questions 1-5 for **both** shoulders!

	LEFT	RIGHT
1. How much pain do you have in your shoulder?	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
2. Are you able to do your work as fully as usual?	☐ Yes ☐ No	☐ Yes ☐ No
3. Is your sleep affected by your shoulder?	☐ Yes ☐ No	☐ Yes ☐ No
4. Are you able to fully participate in recreational/sporting activities?	☐ Yes ☐ No	☐ Yes ☐ No
5. How high can you reach your hand?	☐ Up to waist ☐ Up to sternum ☐ Up to neck ☐ To top of head ☐ Above head	☐ Up to waist ☐ Up to sternum ☐ Up to neck ☐ To top of head ☐ Above head

6. When was the last time you pitched in a game? _____

7. Have you had any injuries throughout the season? Include right or left, how long ago, treatment, etc.

_____

_____

_____

☐ Please check here if you DO NOT want to be contacted for post-season follow-up

8. CONTACT INFORMATION

Phone number: (_____) _____ - _____

Address: _____

_____