

# NO COST SCREEN



## STEP 1 - To be completed by the Coach / ATC / Trainer

Student Name \_\_\_\_\_ Phone #: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Injured Area:  Knee  Back  Shoulder  Ankle  Neck  Other \_\_\_\_\_

Date Injury Occurred: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Complaint: \_\_\_\_\_  
\_\_\_\_\_

How did Injury Occur: \_\_\_\_\_

Referring Coach: \_\_\_\_\_ Email: \_\_\_\_\_

ATC: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Email: \_\_\_\_\_

## STEP 2 - To be completed by the Doctor of Physical Therapy – this form is to have three copies. One for the athlete to take to parents, one for the ATC/ AD, one for the Coach / Trainer. *By signing, you hereby release your screen information to the above stated individuals.*

Athlete Signature: \_\_\_\_\_

### Screen Findings

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### Suggested Plans:

- Skilled therapy is recommended  
\_\_\_\_\_ Times per week for \_\_\_\_\_ weeks
- Do not continue with athletic participation due to injury  
Estimate Return to Play / Training Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Notes: \_\_\_\_\_
- Referred to Orthopedic specialist for further evaluation
- Continue under the following guidelines \_\_\_\_\_  
\_\_\_\_\_
- No therapy is needed at this time. Patient has been given instructions. If not improving, would recommend return for formal therapy within \_\_\_\_ week(s).

Date of Visit : \_\_\_\_/\_\_\_\_/\_\_\_\_ Seen By (Signature): \_\_\_\_\_

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**1444 Falls Ave E.  
Twin Falls, ID 83301  
Phone (208) 736-2574**

**111 Pioneer Ct.  
Jerome, Idaho 83338  
Phone (208) 944-9277**

**931 Center St. Suite C  
Kimberly, ID 83341  
Phone (208) 423-9999**