IMPORTANT INFORMATION:
How the Dance Clinic Works

Welcome to the ***Dance Clinic*** of the Harkness Center for Dance Injuries. The clinic is staffed by a team of senior health professionals (orthopaedists, sports medicine physicians, physical therapists, athletic trainers) specially trained in dance medicine. The Harkness Center is part of the NYU Langone Medical Center, a teaching hospital where junior physicians are trained under the supervision and guidance of the senior staff.

You will be evaluated by several medical professionals during your visit to the dance clinic today. First, a junior physician in the NYU Langone Medical Center will interview and examine you. A senior dance physical therapist or athletic trainer may also be present in the room during this examination.

Following this, a senior physician specializing in the treatment of dance injuries (either an orthopaedic surgeon or a sports medicine physician) will evaluate you. This evaluation will often include teaching and discussion with the other clinical staff.

The senior physician will discuss your diagnosis with you and may recommend further diagnostic testing such as x-ray, MRI, or bone scan. A treatment plan which may include home exercises, dance technique modification, physical therapy, bracing, shoe inserts, medication, injection, and/or surgery will be proposed and discussed. Our healthcare team will address all questions and concerns that you have.

Because the Harkness Center for Dance Injuries is recognized globally for its leadership and expertise in the area of dance medicine, we receive requests from healthcare practitioners worldwide to visit and observe our physicians, physical therapists and athletic trainers at work. Therefore, on occasion, there may be medical observers (other than those already mentioned above) present in the exam room. In keeping with the hospital's privacy practices, all persons will be introduced to you and if you wish, you may request that only the NYU Langone Medical Center personnel remain in the room.

The Harkness Center for Dance Injuries is committed to providing you with quality health care from experienced professionals in dance medicine. It is important to us that your injury be thoroughly evaluated and that all of your questions and concerns be addressed. Please keep in mind that this type of comprehensive evaluation takes time. As a result, your visit with us today is likely to take longer than a typical visit to a physician's private office.

If you would prefer a more private or one-on-one evaluation, you may request to be scheduled for an appointment at the senior physician's private office. Please let us know.

NYU Langone Medical Center

NOTICE OF CHARITY CARE and FINANCIAL RELIEF of INABILITY TO PAY FOR CARE

NYU Hospitals Center is proud of its not-for-profit mission to provide quality care to all who need it. No one is denied admission as a patient on the basis of sex, sexual preference, creed, age, national origin, religion, marital or parental status, handicap, color, or source of payment (within federal and state regulations)

We may be able to help

- If you do not have health insurance
- If your health insurance may not pay enough
- If you think you may not be able to pay for your care.

You may be eligible for the NYU Hospitals Center Financial Assistance program. The program could reduce up to 100% of your bill. We may be able to help you get free or low-cost health insurance. We will also work with you to arrange a manageable payment plan.

It is important that you let us know if you will have trouble paying your bill. Federal and state laws require all hospitals to seek full payment of what they bill patients. We might have to turn unpaid bills over to a collections agency. That could affect your credit status.

Please call our Financial Counseling Office for more information. Our phone number is 1-866-486-9847. We will treat your questions with confidentiality and courtesy.

HARKNESS CENTER FOR DANCE INJURIES' PATIENT MEDICAL HISTORY FORM

Date: _____ / _____ / _____

Name: _____

Date of Birth: _____ / _____ / _____

Sex: ☐M ☐F

Race: ☐ African-American ☐ Asian ☐ Caucasian

☐ Hispanic ☐ Other: _____

Orthopedic History:

CHECK ✓ any orthopedic injury you have had and describe below.

ALSO CIRCLE any injury that caused you to completely stop dance activity, meaning class, rehearsal or performance for two or more days.

☐Ankle / Foot:
- ☐ arthritis
- ☐ impingement
- ☐ os trigonum
- ☐ sesamoiditis
- ☐ stress fracture
- ☐ other_____
- ☐ fracture
- ☐ morton's neuroma
- ☐ plantar fasciitis
- ☐ sprain
- ☐ tendinitis

☐Lower Leg / Shin:
- ☐ compartment syndrome
- ☐ myositis
- ☐ stress fracture
- ☐ fracture
- ☐ shin splints
- ☐ other_____

☐Knee:
- ☐ arthritis
- ☐ bursitis
- ☐ chondromalacia
- ☐ iliotibial band syndrome
- ☐ ligament sprain/rupture (ACL, medial collateral)
- ☐other_____
- ☐ osgood-schlatter's
- ☐ osteochondritis dissecans
- ☐ patellar dislocation
- ☐ patella femoral syndrome
- ☐ patellar tendinitis
- ☐ torn meniscus

☐Thigh:
- ☐ femur fracture
- ☐ muscle strain / tear
- ☐ stress fracture
- ☐ other_____

☐Hip / Pelvis:
- ☐ arthritis
- ☐ bursitis
- ☐ dislocation
- ☐ fracture
- ☐ growth plate injury
- ☐ other _____
- ☐ hip flexor strain
- ☐ labral tear
- ☐ osteitis pubis
- ☐ snapping hip
- ☐ stress fracture

☐Lumbar-Sacral Spine (low back):
- ☐ arthritis
- ☐ disc herniation/protrusion
- ☐ facet syndrome
- ☐ fracture
- ☐ pinched nerve
- ☐ sacroiliac sprain / dysfunction
- ☐ other _____
- ☐ sciatica
- ☐ scoliosis
- ☐ spinal stenosis
- ☐ spondylolysis
- ☐ spondylolisthesis

☐Cervical / Thoracic Spine (neck / mid back)/Ribs:
- ☐ arthritis
- ☐ disc herniation/protrusion
- ☐ facet syndrome
- ☐ fracture
- ☐ pinched nerve
- ☐ scoliosis
- ☐ spinal stenosis
- ☐ spondylolisthesis
- ☐ spondylolysis
- ☐ thoracic outlet syndrome
- ☐ whiplash
- ☐ other _____

☐Shoulder:
- ☐ acromioclavicular joint sprain/separation
- ☐ arthritis
- ☐ bursitis
- ☐ dislocation/subluxation
- ☐ fracture
- ☐ other_____
- ☐ impingement
- ☐ labral tear
- ☐ mechanical instability
- ☐ rotator cuff tear
- ☐ scapulo-thoracic dyskinesis
- ☐ tendinitis

☐Elbow / Wrist / Hand:
- ☐ arthritis
- ☐ carpal tunnel syndrome
- ☐ dislocation
- ☐ fracture
- ☐ osteochondritis (bone chip in joint)
- ☐ sprain
- ☐ tendinitis
- ☐ torn cartilage
- ☐ ulnar neuritis
- ☐ other _____

Give dates and explain treatments for any items checked from the above._____

_____

☐ Yes ☐ No Have any of the above injuries required x-rays, MRI, CT scan, injections, physical/occupational therapy, a brace, a cast, or crutches?
If yes, please state which injuries and tests and give dates:

_____

☐ Yes ☐ No Do any of the above injuries still bother you?
If yes, describe:

Medical History: Check below any medical conditions that you have been diagnosed with:

☐ ADHD(Attention Deficit Hyperactivity Disorder)
☐ Anemia
☐ Asthma
☐ Atlantoaxial instability
☐ Concussion; loss of consciousness
☐ Connective tissue/ rheumatologic disease
☐ Depression
☐ Diabetes
☐ Difficulty controlling bowel
☐ Difficulty controlling bladder
☐ Easy bleeding
☐ Heart infection/Endocarditis
☐ H IV/AIDS
☐ Hormonal imbalance/ Thyroid condition
☐ Enlarged spleen
☐ Heart murmur
☐ Hepatitis
☐ Herpes or MRSA infection
☐ High blood pressure
☐ High cholesterol
☐ Kawasaki disease
☐ Mono (infectious mononucleosis)
☐ Osteopenia or osteoporosis
☐ Numbness, tingling, or weakness in arms

Did you have to stop dancing because of any medical conditions you checked in the medical history boxes at left? ☐ Yes ☐ No

Give dates and treatments for any of the checked items:

_____

_____

Which, if any, of the checked conditions are ongoing?

_____

_____

_____

☐ Yes ☐ No Have you ever been hospitalized?
If so, describe and give date(s):_____

_____

☐ Yes ☐ No Have you ever had surgery?
If so, describe and give date(s):_____

_____

Do you take any medications or supplements?
☐ None ☐ Prescription medication ☐ Over-the-counter medication (non-prescription, e.g. Advil)
☐ Calcium supplements ☐ Daily vitamin ☐ Herbal supplement/tea ☐ Other
If so, please list: _____

Do you have any allergies?
☐ None ☐ Medication ☐ Stinging insects ☐ Food ☐ Environmental ☐ Other
If so, please list all allergies and reaction to allergen(s): _____

Family History:

Has anyone in your family been diagnosed with a medical condition?

☐ Arthritis
☐ Diabetes
☐ Cancer
☐ Heart problem
☐ High blood pressure
☐ Osteoporosis
☐ Pacemaker/implanted defibrillator
☐ Psychological
☐ Seizure
☐ Stroke
☐ Unexplained fainting
☐ Other_____

Give details for any items to the left checked:

_____

_____

_____

Has any family member died of heart problems or had an unexplained sudden death before age 50? ☐ Yes ☐ No

General Health:

Please rate your health: ☐ Excellent ☐Good ☐Fair ☐Poor

What is your height and weight? _____Feet _____Inches _____Pounds

☐ Yes ☐ No Do you currently smoke tobacco? If so, how many cigarettes/cigars per day? _____

How many alcoholic drinks do you have per week on average? (one beer/glass of wine equals one drink) _____

☐ Yes ☐ No Have you ever felt you need to cut down on your drinking?

Are you on a special diet or do you avoid certain types of foods? ☐ Vegetarian ☐ Vegan ☐ Other _____

☐ Yes ☐ No Do you worry about your weight? If you are not satisfied with your weight, what is your ideal weight? ____ lbs

Has anyone recommended that you gain or lose weight?
☐ Dance teacher/director ☐ Family member ☐ Doctor/medical professional ☐ Peer
☐ No one has recommended weight change ☐ Other_____

☐ Yes ☐ No Does your weight often fluctuate by more than 10 lbs?

☐ Yes ☐ No Have you ever had an eating disorder?

Are you interested in nutritional counseling? ☐ Yes ☐ No

On a typical day, how many hours do you sleep? _____ hours
☐ Yes ☐ No Do you feel that this amount is *not* adequate for you?
☐ Yes ☐ No Do you have difficulty falling asleep, difficulty staying awake in the daytime, have loud snoring/gasping to breathe when asleep or have trouble with nightmares or epic dreams?

☐ Yes ☐ No Have you had any major life changes during the past year?
☐ Yes ☐ No Do you feel stressed out or under a lot of pressure?
Over the past two weeks, how often have you lost interest or pleasure in doing things?
☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
Over the past two weeks, how often have you been feeling down, depressed, or hopeless?
☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day

☐ Yes ☐ No Do you have any changes in bowel or bladder function (i.e. increased frequency or control)?
☐ Yes ☐ No Do you experience bowel/bladder leaking with coughing, sneezing, or jumping?
☐ Yes ☐ No Do you have any sensation changes in your genitalia (the area which would come in contact with a bicycle seat)?

Women**:**
Age of first menstrual period: _____
☐ Yes ☐ No Is your menstrual period *irr*egular (does not occur every 28-35 days)?
If yes, what is the time period between cycles (days)? _____
☐ Yes ☐ No Has your menstrual period been *irr*egular in the past?
If yes, at what age did the irregular pattern exist? _____
How long did the irregular pattern exist? _____
What was the length between cycles? _____
☐ Yes ☐ No Do you use a form of birth control that gives you estrogen supplementation?

Dance History:

Which of the following best describes you?
☐ Choreographer ☐ Professional-track dance student ☐ Professional dancer ☐ Recreational dancer
☐ Teacher ☐ Retired ☐ Other_____

What is your primary type of dance?
☐ Ballet ☐ Modern ☐ Musical Theater ☐ Jazz ☐ Hip-hop ☐ African

☐ Tap ☐ Ballroom ☐ Other _____

Name of Primary Dance School or Company: _____

Number of years of professional dancing: _____
At what age did you begin serious dance training? _____
If pointe, at what age did you begin pointe work? _____

How many hours of class do you take in a typical week? ☐0 ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐>20
How many hours do you rehearse and perform in a typical week? ☐0 ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐>20
How many hours per day do you typically train en pointe? ☐0 ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐>20

Do you warm up? ☐ Never ☐ Seldom ☐ About half the time ☐ Usually ☐Always
If so, what does your warm up consist of? _____

Do you stretch? ☐ Never ☐ Seldom ☐ About half the time ☐ Usually ☐Always
When do you stretch? ☐ Before dance ☐ During dance ☐ After dance
How do you stretch? ☐ Static (prolonged holds) ☐ Dynamic (through movement) ☐ Ballistic (bounding)

If you do any cardiovascular or strengthening exercise outside of your warm up on a regular basis, please describe:
_____
How many days per week? _____ For how long per session on average (in minutes)? _____

Type of dance shoe(s) worn most often for dance:
☐ None ☐ Ballet slippers ☐ Character shoes ☐ Jazz oxfords ☐ Pointe Shoes
☐ Sneakers ☐ Street shoes ☐ Other_____

Do you dance on sprung floor (resilient)? ☐ Never ☐ Seldom ☐ About half the time ☐ Usually ☐Always

☐ Yes ☐ No Do you have another job to subsidize your dance life?
If yes, how many hours do you work per week?_____
If yes, what are the physical demands of your job?_____

CURRENT Medical Complaint:

Part of body: _____ Development of Injury: ☐Traumatic / Acute ☐Slow Onset

Rate your current level of pain (circle one. 0 = no pain; 10 = unbearable pain): 0 1 2 3 4 5 6 7 8 9 10

Date of injury, inability to participate in full dance, or "trigger" (the day you decided to seek care for a slow onset injury):

_____/_____/_____; ☐ Morning ☐ Afternoon ☐Evening

If you have had this injury before, when did this injury first occur? _____
☐Dance ☐Non-dance Was this a dance or a non-dance-related injury?

What did you do for the problem(s)? _____
☐Yes ☐No Did the problem(s) get better?

If you waited to seek care, why did you wait? What were your barriers? _____
_____

HARKNESS CENTER *for Dance Injuries*

DIAGNOSIS FORM

FOR OFFICE USE ONLY

Patient Name: _____ ID# _____ DOB: _____ Date: _____ Sex: M / F

DIAGNOSIS: ☐ Preliminary ☐ Final

Body Part:

☐Left ☐ Right

☐Trunk/Back
- ☐Cervical
- ☐Thoracic
- ☐Lumbar /Sacral
- ☐Pelvis

☐Lower Extremity
- ☐Hip/Pelvis
- ☐Thigh
- ☐Knee
- ☐Leg
- ☐Foot/Ankle

☐Upper Extremity
- ☐Shoulder
- ☐Elbow
- ☐Arm/Forearm
- ☐Wrist/Hand
- ☐Head

Muscle/Tendon Injury

☐Contusion
☐Mechanical LBP
☐Metatarsalgia
☐Plantar Fasciitis
☐Tendinopathy/Bursitis
- ☐Achilles
- ☐Biceps brachii
- ☐Calcific
- ☐FHL
- ☐Greater Trochanteric
- ☐ITB
- ☐Lateral Epicondylitis
- ☐Medial Epicondylitis
- ☐Olecranon process
- ☐Patellar
- ☐Peroneal
- ☐Pes Anserine
- ☐Psoas/Iliopsoas
- ☐Quadriceps
- ☐Rotator Cuff
- ☐Tibialis Anterior
- ☐Tibialis Posterior
- ☐Other_____

☐Strain
- ☐Grade I
- ☐Grade II
- ☐Grade III / Rupture

Tissue:
- ☐Quadriceps
- ☐Hamstring
- ☐Adductor
- ☐ITB
- ☐Gastroc
- ☐Soleus
- ☐Abdominals
- ☐Other_____

☐Other_____

Internal Derangement/ Joint Capsule

☐Capsulitis
☐Capsular Strain
☐Cuboid Syndrome
☐Cyst
- ☐Ganglion
- ☐Meniscal

☐Dislocation/Subluxation
☐Failure Orthopedic Implant
☐Hallux Valgus
☐Hernia
☐HNP
☐Impingement
- ☐Anterior
- ☐Posterior

☐Joint Contracture
☐Labral Tear
☐LMT
☐Loose Bodies
☐Mechanical Instability
☐MMT
☐Morton's Neuroma
☐Patellofemoral Syndrome
☐Plica Syndrome
☐Sciatica
☐SI Joint Disorder
☐Synovitis
☐Other_____

Fracture/Bony Injury

☐Apophysitis
- ☐Sever's Disease
- ☐Osgood-Schlatter's

☐Avascular Necrosis
☐Bone Spur
☐Chondromalacia
☐D.J.D.
☐Fracture
- ☐ Dancer's (5th met)
- ☐Jones Fracture
- ☐Metatarsal
- ☐Stress Fracture
  - ☐Calcaneus
  - ☐Femur
  - ☐Fibula
  - ☐ Metatarsal
  - ☐Pelvis
  - ☐ Spondylolysis
  - ☐Talus
  - ☐Tibia
  - ☐Other_____

☐Hallux Limitus
☐Osteochondral injury
☐Os trigonum syndrome
☐Osteoarthritis
☐Osteoporosis
☐Periostiitis
☐Scoliosis
☐Sesamoiditis
☐Spondylolisthesis
☐Other _____

Ligament Injury

☐Sprain
- ☐Grade I
- ☐Grade II
- ☐Grade III / Rupture

Tissue:
- ☐AC Joint
- ☐ACL
- ☐Forefoot
- ☐LCL
- ☐Lateral Ankle
- ☐MCL
- ☐Midfoot
- ☐PCL
- ☐Syndesmosis
- ☐1st MTP Jt
- ☐Other_____

Miscellaneous

☐Concussion
☐Laceration
☐Benign Tumor

FOR OFFICE USE ONLY

Patient Name: _____ ID# _____ DOB: _____ Date: _____ Sex: M / F

What was the mechanism of injury?

☐Inversion ☐Eversion ☐Hyperextension ☐Hyperflexion ☐Rotation

☐Compression ☐Valgus ☐Varus ☐Repetitive Stress ☐Other_____

What was the movement that caused injury?

☐ Body twist/turn ☐Catching object or person ☐Collision ☐ Fall

☐Jump landing (□ 1 or □ 2 leg) ☐Jump take off (□ 1 or □ 2 leg) ☐ Lifting ☐Throwing object

☐ Other:

Injury Type:

☐Acute/sub-acute (<6 wks) ☐Chronic (> 6wks) ☐Chronic Recurrent ☐Post-operative

MD Recommendations:

☐Modify Dance Activity ☐Full Dance Activities ☐No Dance Activities ☐Surgery

Diagnostic Testing

☐X-ray ☐MRI/MRA ☐Bone Scan ☐CT Scan

☐Lab Work ☐Other _____

Time Lost

(Injury caused the dancer to completely stop dance activity, meaning class, rehearsal or performance outside of DOI itself.)

☐Yes

☐No

Date of return to any amount of dance:

_____

 # days lost: _____

Referrals or Outside Recommendations

☐ PCP
☐ Nutritionist/Dietician
☐ Psychologist
☐ Podiatrist
☐ Oncologist
☐ Cardiologist
☐ Sleep Specialist
☐ Other _____

NOTES:_____

_____