

# Park University Athletic Training

# Sport Physical

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Local Phone (including area code)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Sport

Freshman      Sophomore      Junior      Senior

**All information will remain confidential unless written permission is obtained from you to release information.**

**Please answer the following questions, and give details below.**

Please indicate accurate responses	Yes	No
Have you been hospitalized?		
Have you had surgery?		
Have you had an injury or illness in the past year?		
Have you had an injury or illness since you last exam?		
Have any chronic or recurrent medical problems?		
Had a concussion or head injury? Been unconscious?		
Have you been hospitalized due to a head injury?		
Have you been medically disqualified by a physician from sports participation?		
Experienced heat illness: exhaustion, stroke or cramps?		
Do you have a pin, screw or plate in your body?		
Do you have a history of anemia or low iron?		
Had any fractures, sprains, dislocations, strains to your:		
Neck, upper & mid-back, upper spine		
Lower back, lower spine		
Abdomen		
Ribs/Chest		
Shoulder		
Upper Arm		
Elbow		
Wrist		
Hand/Fingers/Thumb		
Hip/Pelvis		
Thigh/Upper Leg		
Knee		
Ankle		
Foot/Toes		
Other (not listed above)		

Please indicate accurate responses	Yes	No
Convulsions, seizures, epilepsy, tremors		
Frequent or chronic cough		
Diabetes: you or a family member		
Fainting or severe dizziness		
Gastrointestinal disorders or ulcers		
Frequent or severe headaches		
Asthma or shortness of breath		
Chest pain, dizziness, shortness of breath during or after exercise		
Hearing problems		
Heart problems (murmur, irregular beat)		
Hernia or rupture		
High/Low blood pressure: you or a family member		
Absence or injury to a kidney, testicle, eye, spleen		
Rheumatic fever		
Skin disorders (dermatitis, rashes)		
Tuberculosis		
Pneumonia		
Kidney disease or infection		
Liver disease (mononucleosis, hepatitis)		
Bleeding disorder		
Had any nerve injuries, burners, stingers, sciatica		
Had a sudden death of a family member under the age of 50 of non-accidental causes.		
Allergies to insect bites, foods, chemicals		
History of: disordered eating patterns, anorexia nervosa, bulimia, compulsive eating behaviors		
Sickle cell trait: you or a family member		
Allergy to medications? PLEASE LIST BELOW.		
Taking herbal preparations? PLEASE LIST BELOW.		

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please indicate accurate responses	Yes	No
Are you taking any prescribed medications (i.e. birth control pills, anti-inflammatory, antibiotics, inhaler, allergy meds)		
Do you wear glasses or contacts during competition?		
Do you wear any devices, such as orthotics, braces, dentures, hearing aids?		

Please Explain
If so, what?
What type?
What type?

Females Only	Yes	No
Do you have irregularity, pain, unusual bleeding or absence of menstrual cycles?		
When was your most recent pelvic exam?		
Are you pregnant?		
Do you take birth control pills or hormone replacement?		
Date of your last menstrual cycle.		

Please Explain
Please Explain
Date:
Date:

Athlete's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

To be completed by a clinician (AT or other)	
Pulse	BPM
Blood Pressure	/
Urinalysis	

Height	Inches
Weight	Lbs.
Pupil Size (circle one):	= R>L R<L

### PHYSICAL EXAM (practitioner only)

Musculoskeletal: per ATC screening	NOR	ABN
Spine (Symm, ROM)		
Shoulder (Symm, ROM)		
Elbow (Symm, ROM)		
Wrist/Hand/Fingers (Symm, ROM)		
Ribs (Symm, ROM)		
Hips/Pelvis (Symm, ROM)		
Knees (Symm, ROM)		
Ankles/Feet/Toes (Symm, ROM)		

General	NOR	ABN
H, E, E, N, T		
Neck		
Skin (rashes, lesions)		
Lungs		
Heart (rate, rhythm, murmurs)		
Abdomen (masses, tenderness, organomegaly)		
Male Genitalia (single or undescended testicle, mass, or hernia)		

### STATUS

(PLEASE CHECK ONE)

Cleared Unrestricted	
Cleared Restricted (please explain below)	
Not Cleared (please explain below)	

### REQUIRES

(IF APPLICABLE)

Further Evaluation	
Medical Records	
Follow-Up (please explain below)	

Comments:

Physician Signature\*

Date