

Only students wanting a physical during check-in in July need to complete this form.



# Colorado Partners in Health LLC

The Spirit of Healthcare at its Best!

**PREPARTICIPATION SPORTS EVAL.**

Name \_\_\_\_\_ School \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Examination \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

Please list all the sports that you will be playing this year \_\_\_\_\_

Answer yes or no to the questions below. Circle any questions that you do not know the answer to.

|   | Yes  | No   |   | Yes  | No   |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
|---|--|--|---|--|--|--------------------------------|-------------------------------|----------------------------------|-------------------------------|-------------------------------|--------------------------------|------------------------------------|--------------------------------|-------------------------------|--------------------------------|-----------------------------------|---------------------------------|-------------------------------|------------------------------------|------------------------------|--------------------------------|--|--|
| 1. Have you had a medical illness or injury since your last checkup or sports physical?   | <input type="checkbox"/>   | <input type="checkbox"/>   | 9. Do you cough, wheeze, or have trouble breathing during or after activity?<br>Do you have asthma?<br><b>Do you have seasonal allergies that require medical treatment?</b>  | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| 2. Have you ever been hospitalized overnight?<br><b>Have you ever had surgery?</b>  | <input type="checkbox"/><br><input type="checkbox"/>   | <input type="checkbox"/><br><input type="checkbox"/>   | 10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, neck roll, foot orthotics, retainer for teeth or hearing aid)?   | <input type="checkbox"/>   | <input type="checkbox"/>   |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| 3. Are you currently taking any prescription or over-the-counter medications, or using pills or an inhaler?<br>Have you ever taken supplements or vitamins to help you lose weight or improve your performance?   | <input type="checkbox"/><br><input type="checkbox"/>   | <input type="checkbox"/><br><input type="checkbox"/>   | 11. <b>Have you had any problems with your eyes or vision?</b>  | <input type="checkbox"/>   | <input type="checkbox"/>   |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| 4. Do you have any allergies?   | <input type="checkbox"/>   | <input type="checkbox"/>   | 12. Have you ever had a sprain, strain, or swelling after being injured?<br><b>Have you broken or fractured any bones or dislocated any joints?</b><br>Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?   | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| 5. <b>Have you ever passed out during or after exercise?</b><br>Have you ever been dizzy during or after exercise?<br>Have you ever had chest pain during or after exercise?<br>Do you get tired more quickly than your friends do during exercise?<br>Have you ever had racing of your heart or skipped heartbeats?<br><b>Have you had high blood pressure or cholesterol?</b><br>Have you ever been told you have a heart murmur?<br>Has any family member or relative died of heart problems or of sudden death before age 50?<br>Have you had a severe viral infection within the past month?<br><b>Has your physician ever denied or restricted your participation in sports for any heart problems?</b> | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> | <p style="text-align: center;"><b>Check joints you've ever injured below:</b></p> <div style="border: 1px solid black; padding: 10px;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Foot</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/> Other</td> </tr> </table> </div> | <input type="checkbox"/> Head  | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Thigh | <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Knee | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Shin/Calf | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Ankle | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Foot | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Hip | <input type="checkbox"/> Other |  |  |
| <input type="checkbox"/> Head   | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Thigh   |   |  |  |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| <input type="checkbox"/> Neck   | <input type="checkbox"/> Forearm   | <input type="checkbox"/> Knee  |   |  |  |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| <input type="checkbox"/> Back   | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Shin/Calf   |   |  |  |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| <input type="checkbox"/> Chest  | <input type="checkbox"/> Hand  | <input type="checkbox"/> Ankle   |   |  |  |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| <input type="checkbox"/> Shoulder   | <input type="checkbox"/> Finger  | <input type="checkbox"/> Foot  |   |  |  |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| <input type="checkbox"/> Upper Arm  | <input type="checkbox"/> Hip   | <input type="checkbox"/> Other   |   |  |  |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| 6. Do you have any current skin problems?   | <input type="checkbox"/>   | <input type="checkbox"/>   | 13. Do you want to weight more or less than you do now? More <input type="checkbox"/> Less <input type="checkbox"/> Neither <input type="checkbox"/><br><b>Do you lose weight regularly to meet weight requirements for your sport?</b>   | <input type="checkbox"/>   | <input type="checkbox"/>   |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| 7. Have you ever been knocked out, become unconscious, or lost your memory?<br><b>Have you ever had a seizure?</b><br>Do you have frequent or severe headaches?<br>Have you ever had a numbness or tingling in your arms, hands, legs, or feet?<br><b>Have you ever had a stinger or burner (pain from neck to arm), or a pinched nerve?</b>  | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/>   | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/>   | 14. Do you have a history of emotional problems?<br>Do you feel stressed out?   | <input type="checkbox"/><br><input type="checkbox"/>                             | <input type="checkbox"/><br><input type="checkbox"/>                             |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |
| 8. Have you ever become ill from exercising in the heat?  | <input type="checkbox"/>   | <input type="checkbox"/>   | <b>Females Only</b><br>15. When was your first menstrual period? _____<br>When was your most recent menstrual period? _____<br>How many periods have you had in the past year? _____  |  |  |                                |                               |                                  |                               |                               |                                |                                    |                                |                               |                                |                                   |                                 |                               |                                    |                              |                                |  |  |

COMMENTS \_\_\_\_\_

I give Colorado Partners in Health LLC permission to perform a sports physical on my child.

Parent/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

MAILING ADDRESS: 4057 West 62<sup>nd</sup> Place - Arvada, CO 80003  
 PHONE: 303-914-0121