Physical Health Questionnaire

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

***This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace** period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.*

Student / Patient Name: ____

Address: ____

City: ___________________________ **State**: _________ **Zip**: ________________

Home Phone: ____________________________ **Cell**: ____________________________________

Date of Birth: _______/________/________ **School / Team**: ____________________________

E-mail: _____________________________ **Sex**: ☐ Male ☐ Female

Whom may we thank for referring you to us? ☐Internet ☐Facebook ☐Google ☐Yelp ☐ Friend ☐Family ☐ Sign & Location ☐ Previous Patient ☐ Other: ____________________________________

Has this Patient / Student had any?

☐ **YES** ☐ **NO** Chronic or recurrent illness or injury?
☐ **YES** ☐ **NO** Any illnesses lasting more than one week?
☐ **YES** ☐ **NO** Rheumatic fever, mononucleosis?
☐ **YES** ☐ **NO** Hospitalizations (overnight or longer)?
☐ **YES** ☐ **NO** Surgery, other than tonsillectomy?
☐ **YES** ☐ **NO** Missing organs (eye, kidney, testicles)?
☐ **YES** ☐ **NO** Allergy to medicine, insects, food?
☐ **YES** ☐ **NO** Seasonal allergies (hay fever)
☐ **YES** ☐ **NO** Problems with heart, blood pressure, cholesterol? Medical treatment?
☐ **YES** ☐ **NO** Racing of your heart or skipped heart beats??
☐ **YES** ☐ **NO** Chest pain with exercise?
☐ **YES** ☐ **NO** Frequent headaches, convulsions, dizziness, fainting?
☐ **YES** ☐ **NO** Dizziness or fainting with exercise?
☐ **YES** ☐ **NO** Concussion, unconsciousness, extremity numbness?
☐ **YES** ☐ **NO** Heat exhaustion, heat stroke, or other heat related problems? Serious joint injuries?
☐ **YES** ☐ **NO** Use of protective equipment or braces?

Has this Patient / Student had any?

☐ **YES** ☐ **NO** Asthma?
☐ **YES** ☐ **NO** Epilepsy or other seizures?
☐ **YES** ☐ **NO** Diabetes?
☐ **YES** ☐ **NO** Eyeglasses or contact lenses?
☐ **YES** ☐ **NO** Dental braces, bridges, plates?

Is there a history of?

☐ **YES** ☐ **NO** Neck injury
☐ **YES** ☐ **NO** Knee injury?
☐ **YES** ☐ **NO** Knee surgery?
☐ **YES** ☐ **NO** Ankle injury?
☐ **YES** ☐ **NO** Broken bones (fractures)?
☐ **YES** ☐ **NO** Other**:** ___________________________

Further History:

☐ **YES** ☐ **NO** Is there a history of family or genetic disease?
☐ **YES** ☐ **NO** Has any family member died suddenly at less than 40 years of age of other than an accident?
☐ **YES** ☐ **NO** Has any family member had a heart attack at less than 55 years of age?
☐ **YES** ☐ **NO** Are you uncomfortably short of breath after running ½ mile without stopping?
☐ **YES** ☐ **NO** Are you taking any medication, if yes list name of medication & condition the medication is for:

____

____

____

What is the most you weighted the past year? ________pounds & least you weighted ________pounds?

For Women only:

How old were you when you had your first menstrual period? ___________ Years / months
In the past year, what is the longest you have gone between menstrual periods? _________

Every year each student shall present to the student's superintendent a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, advanced registered nurse practitioner (ARNP), physician assistant or qualified doctor of chiropractic, to the effect that the student has been examined and may safely engage in athletic competition or participate in physical education programs.

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE:

I am the **parent or legal guardian** of the **Minor or Student Athletic** and do hereby consent Dr. Edgar Romo and staff to perform a physical examination for an assessment for participation in competitive athletics and physical education activities.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

RETURN CHECKS – A minimum charge of **$30.00** will be charged to your account, if the check is returned, we will require future payments to be made by cash or credited card only.

Parent or Legal Guardian Name: ____

Signature: ____ **Date:** ________________________

Romo Chiropractic Physical Examination

Student Athlete / Patient Name: ____ **D.O. B.:** ________________

Weight: _________ **Height:** ______ **Blood Pressure:** ______ / ______ **Pulse:** ________ **Resp:** ________ **Temp:** __________

Vision Corrected: R 20/ _____ L 20/ _____ B 20/ _____ **Uncorrected:** R 20/ _____ L 20/ _____B 20/ _____

SYSTEMS REVIEW	Normal	Abnormal	Describe Abnormal Findings
Skin/Scalp			
Eyes			
Ears: orthoscopic			
Hearing			
Nose			
Throat			
Lymph Nodes			
Thyroid			
Heart			
Lungs			
Abdomen: hernia, masses, other			
Gentio-urinary *(Male Only)*			
Musculoskeletal			
Limitation			
Swelling/tenderness			
Scoliosis screening			
Neurological			
Speech			

Comments regarding abnormal finding: ____

____

Approval for Athletics/Competitive Sports / Work activity / Physical Activity

Based on the above assessment, this student / patient:

☐ Is c**leared** for participation in competitive athletics, physical education activities or work activity

☐ Is **not cleared** for participation in athletic activities or work activity due to ______________________________

Physician's Signature: ________________________________ **Date of Exam:** _______________

Dr. Edgar Romo

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