

PHYSICAL EXAMINATION

Age: _____ Pulse: _____
Height: _____ Blood Pressure: _____
Weight: _____ Visual Acuity: Left 20/ _____
Right 20/ _____

Optional

Urinalysis:
Body Fat %
HCT:
EST VO2 Max:
Audiometry:

Normal

Abnormal

- | | | | | |
|--------------------------|-----|------------------------------|--------------------------|-------|
| <input type="checkbox"/> | 1. | Head | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 2. | Eyes (pupils), ENT | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 3. | Teeth | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 4. | Chest | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 5. | Lungs | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 6. | Heart | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 7. | Abdomen | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 8. | Genitalia | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 9. | Neurologic | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 10. | Skin | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 11. | Physical Maturity | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 12. | Spine, Back | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 13. | Shoulders, Upper extremities | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 14. | Lower extremities | <input type="checkbox"/> | _____ |

Assessment: Full participation
 Limited participation (describe limitations, restrictions):

 Participation contraindicated (list reasons):

Recommendations (equipment, taping, rehabilitation, etc.):

DATE: _____ EXAMINER'S SIGNATURE: _____

EXAMINER'S PHONE: () _____ PRINT EXAMINER'S NAME: _____