

Pre-Participation Physical Exam Form

Welcome to the UPTOWN WELLNESS CENTER

To get & stay healthy, people of all ages receive Chiropractic Care, Massage Therapy & Acupuncture. Your health insurance plan may have these benefits. So that we may verify these health benefits for you & your family, Please provide us with your Health Insurance Card(s).

Who referred you to our Center? **Print Full Name of Patient, Doctor, Website, Directory or Event**

Referred by* Internet website* Health Fair/Event* Met Doctor* Yellow Pages* Drove by
*Name: _____

Please **PRINT CLEARLY.**

Participant FIRST & LAST Name: _____

Current Age: _____ Email address: _____

School / Organization Name _____ Grade # _____ Sports/Activity: _____

Date of most recent physical exam: _____ Problems found: None Other: _____

Current / Previous Restrictions in Sports / Activities: _____

Vaccination Shots: Up to date Other: _____ Foot Arch Supports: Y N Daily Multi-Vitamin: Y N

Recent Injury / Trauma / Surgery: None Auto Injury Sports Injury Other: _____

Explain any **YES** answers below. **CIRCLE** any questions you don't know the answers to.

GENERAL HISTORY: Does the above participant **NOW** have **OR EVER** had any of the following:

YES NO

YES NO

- Loss of consciousness / Head injuries
- Seizures, Dizziness, Fainting, Convulsions
- Hearing / Vision issues (glasses/contacts)
- Ear tubes, ear infections, ruptured ear drum
- Nose, Throat, or breathing problems
- Asthma, allergies, allergic reactions
- Heart murmur, heart problems
- Bleeding diseases
- Lymph node / Lymphatic problems
- Teeth problems (braces, chipped, missing)
- Any Hospital visits / Any Surgery

- High / low blood pressure
- Diabetes
- Hernia
- Absence of a kidney
- Absence of / Undescended testicle
- Absence of any other organ
- Menstrual problems
- Skin problems (severe conditions)
- Recent Auto/Vehicle Accidents
- Taking medication / inhaler (type, reason)
- Down's Syndrome / Genetic condition

Any Organ Problems/Diseases: NONE Heart Liver Kidney Stomach Pancreas Gall bladder

Lungs Intestines Prostate Uterus Ovaries Thyroid Other: _____

► Explain "YES" answers here: _____

► Other problems: _____

ORTHOPEDIC HISTORY: Does the participant **NOW** have **OR EVER** had injuries to any of the following regions?

Please give details of injury, including *right or left* side, *type* of injury, *date* of injury, & any *complications*:

YES NO

YES NO

- Head _____
- Neck _____
- Spine _____
- Shoulder [R or L] _____
- Elbow [R or L] _____
- Wrist [R or L] _____
- Hand [R or L] _____
- Fingers [R or L] _____

- Hip [R or L] _____
- Knee [R or L] _____
- Thigh [R or L] _____
- Calf [R or L] _____
- Ankle [R or L] _____
- Foot [R or L] _____
- Toes [R or L] _____

OTHER: _____

I give permission for the above named participant to receive a pre-participation physical examination. I understand that this exam is for screening purposes only & is not medically diagnostic.

► _____ **X** _____
PRINT NAME: Parent/Guardian/Legal Age Participant **SIGNATURE:** Parent/Guardian/Legal Age Participant **DATE**