

Firstname	Lastname	HAS ID _____
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Date	O Male O Female	DoB	Age (years) O Not sure
Event	Location	<input type="radio"/> Athlete <input type="radio"/> Unified partner	Sport
Delegation		SO Program	

Uses Wheelchair	<input type="radio"/> Yes <input type="radio"/> No				
Uses Assistive Device	<input type="radio"/> Yes <input type="radio"/> No				
Wears splint or brace	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Hand-Wrist	<input type="checkbox"/> Elbow	<input type="checkbox"/> Shoulder	
		<input type="checkbox"/> Knee	<input type="checkbox"/> Hip	<input type="checkbox"/> Back	<input type="checkbox"/> Foot/Ankle



Any diseases or injuries that may affect screening results?					
<input type="checkbox"/> Problems with breathing or lungs	<input type="checkbox"/> Problems with heart	<input type="checkbox"/> Problems with circulation			
<input type="checkbox"/> Pain:	<input type="checkbox"/> lower extremity	<input type="checkbox"/> upper extremity	<input type="checkbox"/> back	<input type="checkbox"/> neck	<input type="checkbox"/> head
<input type="checkbox"/> Sprain:	<input type="checkbox"/> foot or ankle	<input type="checkbox"/> knee	<input type="checkbox"/> hip	<input type="checkbox"/> hand or wrist	<input type="checkbox"/> elbow
				<input type="checkbox"/> shoulder	<input type="checkbox"/> back
				<input type="checkbox"/> neck	
<input type="checkbox"/> Strain:	<input type="checkbox"/> foot	<input type="checkbox"/> leg	<input type="checkbox"/> thigh	<input type="checkbox"/> back or pelvis	<input type="checkbox"/> hand
	<input type="checkbox"/> shoulder or scapula	<input type="checkbox"/> neck		<input type="checkbox"/> forearm	<input type="checkbox"/> arm
<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Fever, illness, or infection				

PHYSICAL ACTIVITY HABITS

On AVERAGE, how many days each week do you do some physical activity?		
<input type="radio"/> 3 - 7 days a week		
<input type="radio"/> 1 - 2 days a week		
What activities do you usually participate in?		
<input type="checkbox"/> Walk/Hike	<input type="checkbox"/> Run / Jog	<input type="checkbox"/> Race walk
<input type="checkbox"/> Sport (football, basketball, hockey, gymnastics, athletics, etc.)	<input type="checkbox"/> Swim	<input type="checkbox"/> Cycle
<input type="checkbox"/> Weight Lift	<input type="checkbox"/> Other	
<input type="radio"/> No regular activity program	Why aren't you physically active?	
<input type="checkbox"/> No available exercise facilities	<input type="checkbox"/> No transportation	<input type="checkbox"/> No money
<input type="checkbox"/> No interest	<input type="checkbox"/> No fitness person to help me	<input type="checkbox"/> Not safe
<input type="checkbox"/> Physically unable	<input type="checkbox"/> No one to exercise with	<input type="checkbox"/> No equipment or clothes
Do you stretch routinely?		
<input type="radio"/> Several times each day	<input type="checkbox"/> Could not elicit response:	
<input type="radio"/> Once each day	<input type="radio"/> Refused to respond	
<input type="radio"/> Occasionally, but not every day	<input type="radio"/> Unable to respond	
<input type="radio"/> No regular stretching	<input type="radio"/> Unable to understand	

FLEXIBILITY

Note Positive (+) or Negative (-) degrees.

HAMSTRING - supine (passive) knee extension	
Left ____ degrees	Right ____ degrees
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete:
	<input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand
CALF - supine (passive) ankle dorsiflexion	
Left ____ degrees	Right ____ degrees
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete:
	<input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand

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ANTERIOR HIP - Modified Thomas Test	
Left _____ degrees	Right _____ degrees
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand

FLEXIBILITY

Note Positive (+) or Negative (-) cm.

SHOULDER - Apley's Test (Functional Shoulder Rotation)			
Left _____ cm.		Right _____ cm.	
LEFT SIDE:	RIGHT SIDE:	LEFT SIDE:	RIGHT SIDE:
<input type="radio"/> Within normal limits	<input type="radio"/> Within normal limits	<input type="radio"/> Within normal limits	<input type="radio"/> Within normal limits
<input type="radio"/> Less flexible than normal	<input type="radio"/> Less flexible than normal	<input type="radio"/> Less flexible than normal	<input type="radio"/> Less flexible than normal
<input type="radio"/> More Flexible than normal	<input type="radio"/> More flexible than normal	<input type="radio"/> More flexible than normal	<input type="radio"/> More flexible than normal

STRENGTH

LEG MUSCLES - Timed Stands Test (functional leg strength)		Time _____ seconds	
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		
ABDOMINAL MUSCLES - Partial Sit-up Test		Number _____	
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		
FOREARM AND HAND MUSCLES - Grip Test		Dominant Hand: <input type="radio"/> Left <input type="radio"/> Right	
LEFT: Trial 1. _____kg. 2. _____kg 3. _____kg.		RIGHT: Trial 1. _____kg. 2. _____kg 3. _____kg.	
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		
UPPER EXTREMITY MUSCLES - Seated Push-up Test (functional strength)		Trial 1 _____ seconds	
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		

BALANCE

EYES OPEN	Single Leg Stance	Left _____ seconds	Right _____ seconds
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		
EYES CLOSED OR COVERED	Single Leg Stance	Left _____ seconds	Right _____ seconds
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		
Functional Reach		Left: _____ cm	Right _____ cm
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		

AEROBIC FITNESS

Heart Rate (beats/min):	Pre-Exercise: _____	End Exercise _____	2 Minutes after _____
<input type="radio"/> Two Minute Step Test Number of Steps _____ Steps			
<input type="radio"/> Alternative Test: Three Minute Walk Test. Distance _____ meters			
<input type="radio"/> Five-Minute Wheel Test Distance _____ Meters.			
<input type="checkbox"/> Education	<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		

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PHYSICAL THERAPIST REFERRAL RECOMMENDED: Yes No

Reasons for Recommendation: Flexibility Strength Balance Aerobic Fitness