Colorado Springs Orthopaedic Group

School Sports Physicals

At CSOG Express Care

Thank you for choosing CSOG Express Care. We are here to help make sure your child is ready for this next sports season. To help us provide the best quality care possible, please read through the below checklist prior to the exam.

1. Fee: $25 Cash Pay rate, insurance is not required
2. Parent/Legal Guardian must complete and sign Patient Health History prior to child being examined. *No person outside of the child's Parent/Legal Guardian can execute the Patient Health History form.*
3. Parent/Legal Guardian must be present with children under 18. *We cannot provide services to unattended minors*. In the event a minor presents without a Parent/Legal Guardian, minor will be asked to return with Parent/Legal Guardian.
    a. Exception: For large groups, a Coach or Athletic Director can stand in for Parent/Legal Guardian *so long as Parent/Legal Guardian has provided consent and Parent/Legal Guardian has completed the Patient Health History form as outlined within item 2*
4. On the Patient Health History form, if any injuries or conditions apply and are marked 'Yes', please provide explanation.
5. For large group or team inquiries, email cvalerio@csog.net
6. Please email us at info@csog.net with any questions

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PREPARTICIPATION SPORTS PHYSICAL EVALUATION

Patient Health History

Please complete page one and two ONLY prior to arriving for exam

Athlete Name: _____________________________ Date of Exam: ____________________

Gender: M / F Date of Birth: ____________ Age: ________ Grade: _____________

School/Program: ____ Sport: ____________________

Home Address: ____ City: ____________ State: _________

Primary Care Physician: __________________________________

EMERGENCY CONTACT

Name: ___________________________________ Relation to Athlete: ________________________

Phone (cell): ______________________________ Phone (work): ____________________________

Please list any medications or allergies:

____

____

Please complete the following. If checked 'Yes' to any of the following, please provide explanation

1. Have you had a medical illness or injury since your last check up or sports physical? Y / N
2. Have you ever been hospitalized overnight? Y / N
3. Have you ever had surgery? Y / N
4. Are you currently taking any prescription or nonprescription (over the counter) medications, or do you use an inhaler? Y / N
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve performance? Y / N
6. Do you have any allergies?
7. Have you ever had a rash or hives develop during or after exercise? Y / N
8. Have you ever passed out during or after exercise? Y / N
9. Have you ever been dizzy during or after exercise? Y / N
10. Have you ever had chest pain during or after exercise? Y / N
11. Have you ever had a racing of your heart or skipped heartbeats? Y / N
12. Do you or have you had high blood pressure or high cholesterol? Y / N
13. Have you ever been told you have a heart murmur? Y / N
14. Has any family member or relative passed away due to heart problems or sudden death before the age of 50? Y / N
15. Have you had a severe viral infection (such as mononucleosis or myocardia) within the last month? Y / N

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16. Has a physician ever denied or restricted your participation in sports for any hear problems? Y / N
17. Do you have any current skin problems such as itching, rash, warts, or fungus? Y / N
18. Have you ever had a head injury or concussion? Y / N
    a. If yes, when? ___________________
    b. Was treatment provided? Y / N
19. Have you ever been knocked out, become unconscious or lost your memory? Y / N
20. Have you ever had a seizure? Y / N
    a. If yes, when? ___________________
21. Do you have frequent or severe headaches? Y / N
22. Have you ever had a numbness or tingling in your arms, hands, legs, or feet? Y / N
23. Have you ever had a stinger, burner, or pinched nerve? Y / N
24. Have you ever become ill from exercising in the heat? Y / N
25. Do you cough, wheeze, or have trouble breathing during or after activity? Y / N
26. Do you have asthma? Y / N
27. Do you have seasonal allergies that require medical treatment? Y / N
28. Do you use any special or corrective equipment or devices (such as a knee brace, ankle brace, protective eye wear, or hearing aids) to help you play sports due to any impairment or prior injury? Y / N
    a. If yes, please provide additional detail: ________________________________
29. Do you wear glasses, contacts, or protective eyewear? Y / N
30. Have you ever had a sprain, strain or swelling after injury? Y / N
31. Have you ever broken or fractured any bones or dislocated any joints? Y / N
32. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Y / N
    a. If yes, please provide additional detail: ________________________________
33. Do you lose weight regularly to meet weigh requirements for you sport? Y / N
34. On a scale of 1-10, pleaser rate your average daily stress level: ______________________________________

FEMALES ONLY

35. When was your first menstrual cycle? ____
36. When was your most recent menstrual cycle? ____
37. How much time do you usually have from the start of one period to the start of another?______ days
38. How many periods have you had in the last year? _______________
39. What was the longest time between periods in the last year? ______________________________

If 'Yes' to any of the above, please provide additional details:
____
____
____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct:

Athlete Signature: ____ Date: ______________________

Parent/Legal Guardian Signature: __________________________________ Date: ____________________

Preparticipation Physical Evaluation

(To be completed at time of physical)

PHYSICAL EXAMINATION

Name: ____Date of Birth:____________

Height: __________Weight:__________% Body fat (optional):_____Pulse:____________

BP: (__/__) (__/__) (__/__)

Vision R 20/_____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	*Initials
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/high			
Knee			
Leg/ankle			
Foot			

*Station based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: ______________________

____

____

____

____

☐ Not cleared for: _________________________Reason:_______________________

Recommndations: ____

____

____

____

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Name of physician (print/type) __________________________Date: ___________

Address: 4110 Briargate Parkway, Suite 300 Colorado Springs, CO 80920 Phone: 719-632-7669

Signature of physician: ____

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