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

Colorado Springs Orthopaedic Group express BONE & JOINT INJURY CARE

North Campus
4110 Briargate Parkway, Suite 300
Colorado Springs, CO 80920
Phone: 719-632-7669
Fax: 719-632-0088

www.csog.net

South Campus
1259 Lake Plaza Drive, Suite 100
Colorado Springs, CO 80906
Phone: 719-632-7669
Fax: 719-632-0088

Colorado Springs Orthopaedic Group

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 ☐ **Y / N** ☐
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 ☐

Colorado Springs Orthopaedic Group

16. Has a physician ever denied or restricted your participation in sports for any **heart** 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: _____

_____

_____

_____

_____

Name of physician (print/type) _____ Date: _____

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

Signature of physician: _____

Colorado Springs Orthopaedic Group

express BONE & JOINT INJURY CARE