Initial Consultation-Athlete

ECHN
Eastern Connecticut Health Network
Strength & Conditioning Program

Name_____ Date_____
DOB_____ Age_____
Father's Name_____Daytime Phone/Cell Phone_____
Mother's Name_____Daytime Phone/Cell Phone_____
Street Address_____City_____Zip_____
Home phone_____ Cell Phone_____
Email_____
Emergency Contact_____Daytime/Cell Phone_____

Athletes and Parents: The health record is a critical element in the determination of an athlete's risk of injury in program participation. Please take time to read and answer all questions before seeing a physician for a physical examination.

Has the athlete suffered from or been diagnosed with any of the following: (Circle)

High blood pressure	Breathing difficulties
Pulmonary disease	Vascular disease
Cancer	Recent illness
Seizures	Diabetes
Allergies	Tremors
Hernia	Back/neck pain
Joint condition/injury	Soft tissue injury
Ankle edema	Unusual fatigue
High cholesterol	High HDL cholesterol

1. Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50?	YES	NO	Don't Know
2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	YES	NO	Don't Know
3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?	YES	NO	Don't Know
4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?	YES	NO	Don't Know
5. Does the athlete have a history of concussion?	YES	NO	Don't Know
6. Has the athlete ever suffered a heat-related illness (heat stroke)	YES	NO	Don't Know
7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	YES	NO	Don't Know
8. Does the athlete take any medication?	YES	NO	Don't Know
9. Is the athlete allergic to any medications or bee stings?	YES	NO	Don't Know
10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries)	YES	NO	Don't Know
11. Has the athlete had an injury in the last year that caused them to miss 3 or more consecutive days of practice or competition?	YES	NO	Don't Know
12. Has the athlete had surgery or been hospitalized in the past year?	YES	NO	Don't Know
13. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or have you had a medical illness diagnosed that has not been resolved in the past year?	YES	NO	Don't Know
14. Are you, the athlete worried about any problem or condition at this time?	YES	NO	Don't Know

Please give details on any "YES" answer from the above health history.

_____
_____
_____
_____
_____

Please complete reverse side

If my health should change so that I could answer "YES" to any of the above questions, I,_____, am responsible for informing my health/fitness professional.

Signature of Athlete: _____Date_____

Signature of Parent/Guardian (If athlete is under 18 years of age)_____
Date_____

Family Physician_____
Physician's Phone_____

Please complete reverse side