PHYSICAL EXAM

To be completed by physician

Name_____

Height_____ Weight_____ Pulse_____ Blood Pressure_____

Vision: R____/____ Uncorrected R____/____Corrected
L____/____ Uncorrected L____/____ Corrected

	Normal	Abnormal Findings	Initials
1. Eyes			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck			
5. Cardiovascular			
6. Chest & Lungs			
7. Abdomen			
8. Skin			
9. Genitalia-Hernia (male)			
10. Musculoskeletal: ROM, strength, etc			
a. neck			
b. spine			
c. shoulders			
d. arms/hands			
e. hips			
f. thighs			
g. knees			
h. ankles			
i. feet			
11. Neuromuscular			

Please Print:

Physician's Name_____
Street Address_____
City_____ State_____ Zip Code_____
Telephone & Extension_____

I certify that I have examined this client and found him/her medically qualified to participate in a fitness program. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is NOT satisfactory).

Physician's Signature_____Date_____

PARTICIPATION RESTRICTIONS:

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