NAME:____

PHYSICAL EXAMINATION

Age: ________ Pulse: _______ Height: ______ Weight: ______ Blood Pressure: ___________ Visual Acuity: Left: 20/____ Right: 20/_____

Normal	Abnormal		
☐	☐	Head	____________________
☐	☐	Eyes (pupils) ENT	____________________
☐	☐	Teeth	____________________
☐	☐	Chest	____________________
☐	☐	Lungs	____________________
☐	☐	Heart	____________________
☐	☐	Abdomen	____________________
☐	☐	Genitalia	____________________
☐	☐	Neurological	____________________
☐	☐	Skin	____________________
☐	☐	Physical Maturity	____________________
☐	☐	Spine, Back	____________________
☐	☐	Shoulders, upper extremities	____________________
☐	☐	Lower extremities	____________________

Assessment:
- ☐ Full participation
- ☐ Limited participation (describe limitations, restrictions):

____

____

- ☐ Participation contraindicated (list reasons):

____

____

Recommendations (equipment, taping, rehabilitation, etc.) ______________________________________

____

DATE: ______________________________ EXAMINER'S SIGNATURE: ______________________________

Please Print or Stamp:

Name: Address: Phone: