ALL AMERICAN SCREENING & TESTING

Baseline Evaluation

DATE: _____

Name _____

Address _____City_____ State_____ Zip_____

Social Security No._____ Date of Birth_____ Age_____

☐ Pre-Placement ☐ Random ☐ Post-Accident ☐Annual Physical ☐ Return to Duty

Physical Examination

General:

Sex:____ Race:____ Height:___'___" Weight: ____ lbs.

BP: Left ____/____ Gait:_____ Speech_____

Disfigurement:_____

Vision: Right 20/_____ Left 20/_____ Both 20/_____

With or w/out corrective lenses. Color Test: _____

Evidence of disease or injury: _____

Hearing: Right ear_____ Left ear_____ Disease or injury_____

Thorax: Heart_____ Pulse_____ Pulse after exercise_____

Lungs_____

Abdomen: Scars_____ Abnormal masses_____

Tenderness_____ Hernia: _____

If so, where?_____ Positive Kidney punch _____

Extremities: Upper_____ Lower_____

Reflexes: Knee Jerks Right_____ Left_____

Spine: _____ Evidence of disease or injury_____

ROM:	Cervical Spine	Lumbar Spine
Flexion	0 1 2 3 P	0 1 2 3 P
Extension	0 1 2 3 P	0 1 2 3 P
Left lateral flexion	0 1 2 3 P	0 1 2 3 P
Right lateral flexion	0 1 2 3 P	0 1 2 3 P
Left rotation	0 1 2 3 P	0 1 2 3 P
Right rotation	0 1 2 3 P	0 1 2 3 P

ROM (grade restriction)Key:
0=No Restriction 3=Severe Restriction
1=Mild Restriction P=Pain
2=Moderate Restriction

Comments_____

_____

Health History

(check appropriate box)

Yes	No	
☐	☐	Head or spinal injuries
☐	☐	Syphilis
☐	☐	Kidney disease
☐	☐	Urethral discharge
☐	☐	Seizures, fits, convulsions, or fainting
☐	☐	Gonorrhea
☐	☐	Muscular disease
☐	☐	Diabetes
☐	☐	Suffering from any other disease
☐	☐	Extensive confinement by illness or injury
☐	☐	Gastrointestinal ulcer
☐	☐	Nervous stomach
☐	☐	Rheumatic fever
☐	☐	Asthma
☐	☐	Cardiovascular disease
☐	☐	Tuberculosis
☐	☐	Permanent defect from illness or injury
☐	☐	Psychiatric disorder
☐	☐	Have you had back pain
☐	☐	Have you had neck pain
☐	☐	Headaches on a regular basis
☐	☐	Any other nervous disorder

If answer to any of the above questions is yes, explain:

_____

_____

_____

_____

_____

_____

_____

_____

Notes_____

_____

☐ **CHECK HERE IF NOT QUALIFIED**

Dr.'s/EMT signature _____