

Physical Health Questionnaire

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.



Student / Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____

Date of Birth: ____/____/____ **School / Team:** _____

E-mail: _____ **Sex:** Male Female

Whom may we thank for referring you to us? Internet Facebook Google Yelp Friend
 Family Sign & Location Other: _____

Has this Patient / Student had any?

- YES NO Chronic or recurrent illness or injury?
- YES NO Any illnesses lasting more than one week?
- YES NO Rheumatic fever, mononucleosis?
- YES NO Hospitalizations (overnight or longer)?
- YES NO Surgery, other than tonsillectomy?
- YES NO Missing organs (eye, kidney, testicles)?
- YES NO Allergy to medicine, insects, food?
- YES NO Seasonal allergies (hay fever)
- YES NO Problems with heart, blood pressure, cholesterol? medical treatment?
- YES NO Racing of your heart or skipped heart beats??
- YES NO Chest pain with exercise?
- YES NO Frequent headaches, convulsions, dizziness, fainting?
- YES NO Dizziness or fainting with exercise?
- YES NO Concussion, unconsciousness, extremity numbness?
- YES NO Heat exhaustion, heat stroke, or other heat related problems? serious joint injuries?
- YES NO Use of protective equipment or braces?

Has this student had any?

- YES NO Asthma?
- YES NO Epilepsy or other seizures?
- YES NO Diabetes?
- YES NO Eyeglasses or contact lenses?
- YES NO Dental braces, bridges, plates?

Romo Chiropractic, Inc.

1101 Standiford Ave, Suite D-2 • Modesto, CA 95350

Phone: (209) 571-1999 • Fax: (209) 571-1968 • E-Mail: info@modesto-chiro.com

Is there a history of?

- YES NO Neck injury
 YES NO Knee injury?
 YES NO Knee surgery?

- YES NO Ankle injury?
 YES NO Broken bones (fractures)?
 YES NO Other: _____

Further History:

- YES NO Is there a history of family or genetic disease?
 YES NO Has any family member died suddenly at less than 40 years of age of other than an accident?
 YES NO Has any family member had a heart attack at less than 55 years of age?
 YES NO Are you uncomfortably short of breath after running ½ mile without stopping?
 YES NO Are you taking any medication, if yes list name of medication & condition the medication is for:

What is the most you weighted the past year? _____pounds & least you weighted _____pounds?

For Women only:

How old were you when you had your first menstrual period? _____ Years / months
In the past year, what is the longest you have gone between menstrual periods? _____

Every year each student shall present to the student's superintendent a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, advanced registered nurse practitioner (ARNP), physician assistant or qualified doctor of chiropractic, to the effect that the student has been examined and may safely engage in athletic competition or participate in physical education programs.

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE:

I am the **parent or legal guardian** of the **Minor or Student Athletic** and do hereby consent Dr. Edgar Romo and staff to perform a physical examination for an assessment for participation in competitive athletics and physical education activities.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

RETURN CHECKS – A minimum charge of **\$30.00** will be charged to your account, if the check is returned, we will require future payments to be made by cash or credited card only.

Parent or Legal Guardian Name: _____

Signature: _____

Date: _____

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