

# SPORTS/CAMP PREPARTICIPATION HISTORY

*My Family Chiropractor*

655 NW Burnside Rd, Suite 5  
Gresham, Oregon 97030

Daniel DesJardins, D.C.

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ M / F Date: \_\_\_\_\_

1. Have you ever been hospitalized?  Yes  No
2. Have you ever had surgery?  Yes  No
3. Are you currently taking medications?  Yes  No
4. Do you have any allergies (medications, bees, insect bites, food, etc.)?  Yes  No
5. Have you ever passed out during exercise?  Yes  No
6. Have you ever been dizzy during exercise?  Yes  No
7. Have you ever had chest pain?  Yes  No
8. Do you have a persistent cough or sore throat?  Yes  No
9. Do you get short of breath easily or wheeze?  Yes  No
10. Do you wheeze after exercise?  Yes  No
11. Do you tire more quickly than your friends during exercise?  Yes  No
12. Have you ever had high blood pressure?  Yes  No
13. Do you get frequent nosebleeds?  Yes  No
14. Do you bruise easily?  Yes  No
15. Have you ever been told you have a heart murmur?  Yes  No
16. Have you ever had racing of your heart or skipped beats?  Yes  No
17. Has anyone in your family died of heart problems or a sudden death before the age of 40?  Yes  No
18. Do you have any skin problems (itching, moles, breaking out, rashes, sores, bumps, etc.)?  Yes  No
19. Have you ever had a head injury or concussion?  Yes  No
20. Have you every been knocked out?  Yes  No
21. Have you ever fainted or felt like you were about to faint?  Yes  No
22. Have you ever had a seizure, ringing in your ears or weird visual changes?  Yes  No
23. Have you ever had stinging, burning or tingling in your arms or legs?  Yes  No
24. Have you ever been paralyzed?  Yes  No
25. Have you had any other nerve problems or nervous disorders?  Yes  No
26. Have you ever injured (sprained, dislocated, fracture, etc.):
  - Hand  Shoulder  Thigh
  - Wrist  Neck  Knee
  - Forearm  Chest  Shin/Calf
  - Elbow  Back  Ankle
  - Arm  Hip  Foot
27. Have you ever had heat cramps or other muscle cramps?  Yes  No
28. Have you ever been dizzy or passed out in the heat?  Yes  No
29. Do any of your joints feel unstable or unsteady?  Yes  No
30. Do you often have backaches, neck aches, or sore bones or sore joints?  Yes  No
31. Do you think you have a hernia, groin pain, or weak muscles?  Yes  No
32. Do you use special pads or braces (including teeth)?  Yes  No
33. Do you wear glasses or require special eye wear?  Yes  No
34. Have you ever had spleen, kidney, liver or bowel problems?  Yes  No
35. Do you have any missing organs?  Yes  No
36. Do you or have you had any chronic or recurrent illness?  Yes  No
37. Do you have any contagious disease or infections?  Yes  No
38. Are you concerned about your weight?  Yes  No
39. Are you concerned about your height?  Yes  No
40. Are you concerned about your appearance?  Yes  No
41. Does it burn when you urinate?  Yes  No
42. Do you have any questions about drugs, alcohol or tobacco?  Yes  No
43. Do you have any questions about contraception?  Yes  No
44. Do you have any questions about discharge, genital sores or venereal diseases?  Yes  No
45. Males only: Do you have any questions about testicle problems?  Yes  No
46. Female only: Do you have any questions about breast problems?  Yes  No
47. Female only: Have you ever missed a period?  Yes  No
48. Female only: Are you or could you be pregnant?  Yes  No
49. Female only: When was your first period? \_\_\_\_\_
50. Female only: When was your last period? \_\_\_\_\_
51. Have you ever had one of the following:
  - Mononucleosis  Tuberculosis  Eye Problems
  - Hepatitis  Pneumonia  Stomach Problems
  - HIV  Diabetes1  Ear Infections
  - Asthma  Headaches

52. Any other information you think may be important? \_\_\_\_\_

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