

Firstname	Lastname	HAS ID _____
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Date	O Male O Female	DoB	Age (years) O Not sure
Event	Location	O Athlete O Unified partner	Sport
Delegation		SO Program	
Cell phone number	Number is O Athlete's O Parent's / Guardian's		
Providing a phone number is optional. It will be used to send a text reminder if any follow up is recommended after screening.			

Uses Wheelchair <input type="radio"/> Yes <input type="radio"/> No	Altitude (m) check one <input type="radio"/> 0 to 1,500 <input type="radio"/> 1,501 to 3000 <input type="radio"/> >3,000
Uses Assistive Device <input type="radio"/> Yes <input type="radio"/> No	
Wears splint or brace <input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Hand-Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Back <input type="checkbox"/> Foot/Ankle	

Any diseases or injuries that may affect screening results?

<input type="checkbox"/> Problems with breathing or lungs	<input type="checkbox"/> Problems with heart	<input type="checkbox"/> Problems with circulation
<input type="checkbox"/> Pain: <input type="checkbox"/> lower extremity	<input type="checkbox"/> upper extremity	<input type="checkbox"/> back <input type="checkbox"/> neck <input type="checkbox"/> head
<input type="checkbox"/> Sprain: <input type="checkbox"/> foot or ankle <input type="checkbox"/> knee <input type="checkbox"/> hip <input type="checkbox"/> hand or wrist	<input type="checkbox"/> elbow <input type="checkbox"/> shoulder <input type="checkbox"/> back <input type="checkbox"/> neck	<input type="checkbox"/> arm <input type="checkbox"/> shoulder or scapula <input type="checkbox"/> neck
<input type="checkbox"/> Strain: <input type="checkbox"/> foot <input type="checkbox"/> leg <input type="checkbox"/> back or pelvis <input type="checkbox"/> hand	<input type="checkbox"/> Fever, illness, or infection	
<input type="checkbox"/> Skin Problems		

Have you fallen in your home in the past year? Yes No

Do you stretch routinely?

<input type="radio"/> Several times each day	<input type="radio"/> Could not elicit response:
<input type="radio"/> Once each day	<input type="radio"/> Refused to respond
<input type="radio"/> Occasionally, but not every day	<input type="radio"/> Unable to respond
<input type="radio"/> No regular stretching	<input type="radio"/> Unable to understand



FLEXIBILITY **Note Positive (+) or Negative (-) degrees**

HAMSTRING - supine (passive) knee extension	
Left ____ degrees	Right ____ degrees
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand	<input type="checkbox"/> Education Between -90 and -16° or asymmetry
CALF - supine (passive) ankle dorsiflexion	
Left ____ degrees	Right ____ degrees
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand	<input type="checkbox"/> Education Less than +10° or asymmetry
ANTERIOR HIP - Modified Thomas Test	
Left ____ degrees	Right ____ degrees
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand	<input type="checkbox"/> Education Between -90 and -11° or asymmetry

Note Positive (+) or Negative (-) cm.

SHOULDER - Apley's Test (Functional Shoulder Rotation)	
Left ____ cm.	Right ____ cm.
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand	<input type="checkbox"/> Education Between -90 and -16 cm between fingertips or asymmetry

STRENGTH

On average, how many days a week do you do physical activities for muscle strength?
(Physical activities for muscle strength include lifting weights, using elastic bands, push ups or situps)
 No days 1-2 days 3-6 days Every Day

How much of this strength activity is related to Special Olympics training, practice, or competition?
 None Some Most All

Could not elicit response:
 Refused to respond
 Unable to respond
 Unable to understand

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LEG MUSCLES - Times Stand Test (Functional Leg Strength)	Time _____ seconds
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand	<input type="checkbox"/> Education >20 seconds
ABDOMINAL MUSCLES - Partial Sit-up Test	Number _____
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand	<input type="checkbox"/> Education < 25 in 1 minute
FOREARM AND HAND MUSCLES - Grip Test	Dominant Hand: <input type="radio"/> Left <input type="radio"/> Right
LEFT Trial 1. _____ kg. 2. _____ kg. 3. _____ kg.	RIGHT Trial 1. _____ kg. 2. _____ kg. 3. _____ kg.
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand	<input type="checkbox"/> Education see reference sheet
UPPER EXTREMITY MUSCLES - Seated Push-up Test (Functional Strength)	Push-up _____ seconds
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand	<input type="checkbox"/> Education < 5 seconds

BALANCE

EYES OPEN	Single Leg Stance	Left _____ seconds	Right _____ seconds
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		<input type="checkbox"/> Education < 20 seconds	
EYES CLOSED OR COVERED	Single Leg Stance	Left _____ seconds	Right _____ seconds
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		<input type="checkbox"/> Education < 10 seconds	
FUNCTIONAL REACH	Left: _____ cm	Right _____ cm	
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand		<input type="checkbox"/> Education < 20 cm	

AEROBIC FITNESS

On AVERAGE, how many days each week do you do some physical activity? <input type="radio"/> No Regular Program <input type="radio"/> 1-2 days <input type="radio"/> 3-6 days <input type="radio"/> Every Day
On AVERAGE, how many days a week is your physical activity at a moderate level? (Moderate means working hard enough to make your heart beat faster and possibly begin to sweat. Examples: fast walk, swimming, bicycling) <input type="radio"/> No days <input type="radio"/> 1-2 days <input type="radio"/> 3-6 days <input type="radio"/> Every Day
How much of this moderate physical activity is related to Special Olympics? <input type="radio"/> None <input type="radio"/> Some <input type="radio"/> Most <input type="radio"/> All
<input type="radio"/> Could not elicit response: <input type="radio"/> Refused to respond <input type="radio"/> Unable to respond <input type="radio"/> Unable to understand

If you have no regular activity program, please tell us why?

<input type="checkbox"/> No available exercise facilities	<input type="checkbox"/> No transportation	<input type="checkbox"/> No money
<input type="checkbox"/> No interest	<input type="checkbox"/> No fitness person to help me	<input type="checkbox"/> Not safe
<input type="checkbox"/> Physically unable	<input type="checkbox"/> No one to exercise with	<input type="checkbox"/> No equipment or clothes

How is HR being Measured Manual (Pulse) MIO Heart rate monitor Pulse Oximeter

Heart Rate (beats/min):	Pre-Exercise HR _____	End Exercise HR _____	2 Minutes after :HR _____
O₂ Saturation (%)	O ₂ Sat _____	O ₂ Sat _____	O ₂ Sat _____
O Two Minute Step Test	Number of Steps _____ Steps		
O Five-Minute Wheel Test	Distance _____ Meters		
<input type="checkbox"/> Unable to test because athlete: <input type="radio"/> Refused to perform <input type="radio"/> Unable to perform <input type="radio"/> Unable to understand	<input type="checkbox"/> Education		

PHYSICAL THERAPIST REFERRAL RECOMMENDED	<input type="radio"/> Yes <input type="radio"/> No
REASONS FOR RECOMMENDATION	<input type="checkbox"/> Flexibility <input type="checkbox"/> Strength <input type="checkbox"/> Balance <input type="checkbox"/> Aerobic Fitness
PRIMARY CARE PHYSICIAN REFERRAL RECOMMENDED	<input type="radio"/> Yes <input type="radio"/> No
REASONS FOR RECOMMENDATION: (brief outline of medical issue identified)	