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|-------------------|-----------------|---------------------|
| First Name | Lastname | HAS ID _____ |
|-------------------|-----------------|---------------------|

| | | | |
|---|---|---|--|
| Date: | <input type="checkbox"/> Male <input type="checkbox"/> Female | DoB: | Age: (years) <input type="checkbox"/> Not sure |
| Event: | Location: | <input type="checkbox"/> Athlete <input type="checkbox"/> Unified partner | Sport: |
| Delegation: | | SO Program: | |
| Cell phone number | Number is: <input type="checkbox"/> Athlete's <input type="checkbox"/> Parent's / Guardian's | | |
| Providing a phone number is optional. It may be used to call or send reminders if follow up is recommended after screening. | | | |

Body Composition

Height ____ . ____ cm
Measure up to 0.1 cm

Height ____ inches
Measure up to 1/8 inch



Weight ____ . ____ kg
Measure up 0.1 kg

Weight ____ lbs. ____ oz.
Measure up to 1/2 oz.



Waist Circumference ____ . ____ cm inches

Waist to Height Ratio _____
(waist circumference ÷ height)

_____ **BMI** (20 years of age and over)

_____ **BMI** Percentile (under 20 years of age)

Referral made for BMI follow Up? Yes No Urgent Not Urgent

Bone Mineral Density Test (Athletes MUST be at least 20 years old to screen)

T-score Left heel ____ . ____ -4.0 to + 5.0

Unable to test

Right heel ____ . ____ -4.0 to + 5.0

Age under 20

Athlete refused

Athlete unable to cooperate

Unusual heel shape

Referral made for BMD follow Up? Yes No Urgent Not Urgent

Blood Pressure

Right arm _____/_____

Left Arm _____/_____

Referral made for BP follow Up? Yes No Urgent Not Urgent

Nutrition – Food and Beverage Habits

Do you take vitamin D supplements? Yes No Don't know

What do you usually drink when you are thirsty? (select all that apply)

- Water
- Fruit juice
- Soft drink diet non-diet

- Sports drink
- Milk product (includes soy)
- Energy drink

Other _____

| | | |
|---|--|--|
| <p>Calcium Foods and Beverages</p> <p><input type="radio"/> less than 1 serving per day</p> <p><input type="radio"/> 1-2 servings per day</p> <p><input type="radio"/> 3-5 servings per day</p> <p><input type="radio"/> more than 5 servings per day</p> <p><input type="radio"/> never</p> | <p>Sweetened Beverages</p> <p><input type="radio"/> daily</p> <p><input type="radio"/> weekly</p> <p><input type="radio"/> monthly</p> <p><input type="radio"/> never</p> | <p>Fast food</p> <p><input type="radio"/> daily</p> <p><input type="radio"/> weekly</p> <p><input type="radio"/> monthly</p> <p><input type="radio"/> never</p> |
| <p>Fruits and Vegetables</p> <p><input type="radio"/> less than 1 serving per day</p> <p><input type="radio"/> 1-2 servings per day</p> <p><input type="radio"/> 3-5 servings per day</p> <p><input type="radio"/> more than 5 servings per day</p> <p><input type="radio"/> never</p> | <p>Snack Foods</p> <p><input type="radio"/> daily</p> <p><input type="radio"/> weekly</p> <p><input type="radio"/> monthly</p> <p><input type="radio"/> never</p> | |

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Physical Activity

How many days each week do you exercise for at least 30 minutes?

- no days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

Do you exercise outside of your Special Olympics training? Yes No

If yes, what do you do? (Select all that apply)

- Weights Run/Jog Walk Dance Sports Exercise DVD, Wii Job Other

If no, what is the reason? (Select all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> No interest | <input type="checkbox"/> No money | <input type="checkbox"/> No time |
| <input type="checkbox"/> Do not know how | <input type="checkbox"/> Physically unable | <input type="checkbox"/> No place to exercise |
| <input type="checkbox"/> No transportation | <input type="checkbox"/> No one to do it with | <input type="checkbox"/> Other |

How many hours a day do you watch television or play computer/video games?

- 0 hours 1–2 hours 3-4 hours 5-6 hours Over 6 hours

Hand Washing

When are the most important times to wash your hands? (select all that apply)

- After using the toilet Before eating or touching food other reason No reasons given

Did you use soap when last washing your hands? Yes No **Do you have soap at home?** Yes No

Sun Safety

Do you do anything to protect your skin in the sun? Yes No

If yes, what do you do to protect your skin in the sun? (select all that apply)

- use sunscreen wear a hat wear long sleeves seek shade wear sunglasses I do nothing

If no, what is the reason? (select all that apply)

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Did not know it was important | <input type="checkbox"/> No money to buy protection | <input type="checkbox"/> Other |
| <input type="checkbox"/> Don't get sunburned | <input type="checkbox"/> Like to be tan | |

Tobacco Use

Do you use tobacco? Yes No **If yes, how frequently?** daily weekly monthly

Do any of your friends or family members smoke near you? Yes No

If yes, what do you do when they are smoking near you? (select all that apply)

- Ask them to stop Leave the room Smoke I do not do anything Other

Check out: Follow up care recommended?

- | | | |
|-----|--|---|
| BMI | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="radio"/> Urgent <input type="radio"/> Not Urgent |
| BMD | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="radio"/> Urgent <input type="radio"/> Not Urgent |
| BP | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="radio"/> Urgent <input type="radio"/> Not Urgent |