Outdoor Achievement Group, L.L.C.

Individual, Family, & Group Psychotherapy

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History & Pre-Participation Exam

Patient's Name ____ Birth Date ______/______/______

Address _________________________________ City ___________________ State _____ Zip __________

Parent(s) or Guardian(s) Name ____

Medical History

Have you had any serious injury or illness since your last check-up?	YES	NO
Do you have an ongoing or chronic illness?		
Have you ever been hospitalized overnight?		
Have you ever had surgery?		
Are you currently taking any medication? (List Medications Below)		
Do you think you are in good health?		
Do you have any allergies (include food allergies)?		
Have you ever experienced rash or hives following exercise?		
Have you ever passed out during or after exercise?		
Have you ever been dizzy during or after exercise?		
Have you ever had chest pain during or after exercise?		
Do you tent to tire more quickly than your friends during exercise?		
Have you ever head racing of your heart or skipped heartbeats?		
Have you had high blood pressure or high cholesterol?		
Have you ever been told you have a heart murmur?		
Has a family member or relative dies of heart problems or sudden death before age 50?		
Is there a family history of heart problems in a close relative younger than age 50?		
Have you had severe heart infection?		
Has a physician ever denied or restricted your participation in sports for any heart problem?		
Have you had a severe viral infection within the last 6-months?		
Do you have any current skin problems (itching, rash, blisters, acne, warts, or fungus)?		
Have you ever had a head injury or concussion?		
Have you ever been knocked out, become unconscious, or lost your memory?		
Have you ever had a seizure?		
Do you have frequent or severe headaches?		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
Have you ever become ill following exercise in the heat?		
Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Do you have asthma?		
Do you have seasonal allergies which require medical treatment?		
Have you had any problem with your eyes or vision?		
Do you wear glasses, contacts, or protective eyewear?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had problems with pain or swelling in muscles, tendons, bones, or joints?		
Do you want to weigh more or less than you do now?		
Do you feel stressed out?		

Explain "Yes" answers here (use reverse side if needed) **:**

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Physical Exam (this section must be completed by a medical care provider)

Patient's Name ____ Birth Date ______/______/______

Height: __________ Weight: __________ Pulse: __________ BP: ______/______

Vision: R 20/_____ L 20/_____ Corrected: YES NO

MEDICAL	NORMAL	ABNORMAL (findings)	INITIALS*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL (findings)**	**INITIALS***
Head			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*This is a station-based exam only.

☐ Cleared ☐ Not Cleared ☐ Cleared with Restrictions (see below)

Restrictions/Reasons:

____

____

____.

I certify that on this date I examined this individual. Based on my examination and the patient's medical history as furnished to me I find no reason that would make it medically inadvisable for this individual to participate in outdoor activities including hiking, canoeing, and rock climbing **(see restrictions above)**.

_________________________________ _________________________________

_________________________________ **Examiner's Signature**

_________________________________ _________________________________

Examiner's Name and Address (print or stamp) **Telephone Number**

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