Prepcycle Entrance Evaluation

Student Name: ______________________________________

Home Dojo: ☐ **Fort Collins** ☐ **Johnstown** ☐ **Longmont** ☐ **Broomfield**

Today's Date ____________________ **Date of Birth:** _____________________ **Age at exam:** __________________

Sex assigned at birth: ☐ Male ☐ Female ☐ Other _____________**Gender:** ☐ Male ☐ Female ☐ Other ________________

Preferred Pronouns: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ **Other** _____________________________

Address: ____

Emergency Contact: __________________________________ **Relationship to Student:** ______________________

Phone: (H)__________________**(W)**___________________**(C)**________________ **Email:** _______________________

For Minors: Name of parents and/or responsible parties: ____

May we have your permission to contact responsible parties about above-named student? ☐ Yes ☐ No.

May we leave a message? **Home:** ☐ Yes ☐ No **Work:** ☐ Yes ☐ No **Cell:** ☐ Yes ☐ No

Primary Care Provider's Name: _____________________________ **Address:** _______________________________

PCP's Phone number: _____________________ **Dentist and phone #** _____________________________________

Preferred hospital in case of emergency: _______________________ **Ins Company and #** ____________________

Medical Conditions: (such as asthma, diabetes, migraine headaches)

1)______________________ 2) _____________________ 3) _____________________ 4) ____________________

Medications: (please list all prescription, over the counter and supplements taken on a regular basis)

1)______________________ 2) _____________________ 3) _____________________ 4) ____________________

Do you have any ALLERGIES: ☐ Yes ☐ No If yes, please list below

☐ Medicines______________ ☐ Food _______________ ☐ Stinging Insects ______________ ☐ Pollen _____________

Do you carry an Epi pen with you? ☐ Yes ☐ No

Have you had any surgeries? (please list surgery and date)

1)______________________ 2) _____________________ 3) _____________________ 4) ____________________

Do you have any **physical concerns** about participating in the PrepCycle process? ______________________________

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Do you currently have any **injuries or health conditions** that will make it necessary for you to modify your training?

If so please describe: ____

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Please answer the questions below by marking the Yes or No box. Circle questions you do not know answers for.

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood Pressure ☐ Heart Murmur ☐ High Cholesterol ☐ Heart Infection ☐ Kawasaki disease ☐ Other:		
9. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?	YES	NO
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	YES	NO
26. Do you have asthma?		
27. Have you ever been diagnosed with depression or anxiety?		
28. Do you or have you ever had thoughts of suicide?		
29. Have you been diagnosed with ADHD or ADD?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
If yes, how many diagnosed concussions have you had? How much time did you miss for each concussion?		
35. Do you have a history of seizure disorder?		
36. Do you have headaches with exercise?		
37.Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
38. Have you ever been unable to move your arms and legs after being hit or falling?		
39. Have you ever become ill while exercising in the heat?		
40. Do you get frequent muscle cramps when exercising?		
41. Were you born without or are missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
42. Have you had any problems with your eyes or vision?		
43. Have you had any eye injuries?		
44. Do you wear glasses or contact lenses?		
45. Have you ever had a problem with alcohol or substance abuse?		
46. Are you trying to gain or lose weight?		
47. Are you on a special diet or do you avoid certain types of foods?		
48. Have you ever had or have an eating disorder?		
49. Do you have any concerns that you would like to discuss with a doctor or provider?		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give the consent for an exchange of health information between Ripple Effect Martial Arts and my health Care Providers.

Signature of Parent or Guardian or Emancipated student: ________________________________

Printed Name ______________________________ **Date:**______________