

Physical Examination

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Youth Name: _____ Date: _____

Instructions: To be completed by a qualified physician. A person responsible for the child must be present to give the medical history and to hear and discuss recommendations.		
Height:	Weight:	Temperature:
Blood Pressure:	Pulse:	Respiration:

Vision Screening:	Left Eye:	Right Eye:	Both:
Vision Follow-Up Required: Yes No (circle one)			
Remarks:			

HEAD:	Normal:() Abnormal:()	Remarks:
EYES:	Normal:() Abnormal:()	Remarks:
EAR CANALS:	Normal:() Red:()	Bulging:() Retracted:()
TM's:	Normal:() Red:()	
CERNUM OBSTRUCTED:	Right: () Left:()	
HEARING:	Normal:() Abnormal:()	Remarks:
NOSE:	Normal:() Abnormal:()	Remarks:
THROAT:	Normal:() Red:()	Hypertrophied:()
TONSILS:	Yes: () No: ()	
ADENOPATHY:	Yes: () No: ()	
ORAL HYGIENE:	Good: () Fair: () Poor: ()	
NECK:	Normal:() Abnormal:()	Remarks:
CHEST:	Normal:() Abnormal:()	Remarks:
LUNGS:	Normal:() Abnormal:()	Remarks:
HEART:	Normal:() Abnormal:()	Type:
MURMUR:	Yes: () No: ()	
	Functional: () Nonfunctional: ()	
ABDOMEN:	Normal:() Abnormal:()	Remarks:
GENITALIA:	Normal:() Abnormal:()	Remarks:
HERNIA:	Normal:() Abnormal:()	Remarks:
SPINE:	Normal:() Abnormal:()	Remarks:
SCOLIOSIS:		
BACK:	Normal:() Abnormal:()	Remarks:
EXTREMITIES:	Normal:() Abnormal:()	Remarks:
SKIN:	Normal:() Abnormal:()	Remarks:

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GENERAL APPEARANCE:
<i>GAIT:</i>
<i>POSTURE:</i>
<i>NUTRITIONAL STATUS:</i>
<i>BODY TYPE:</i>
<i>BEHAVIOR:</i>

GROSS NEUROLOGICAL EXAM:	Normal: () Abnormal: () Remarks:
SENSORY ABNORMALITIES:	Yes: () No: () Explain:
MOTOR ABNORMALITIES:	Yes: () No: () Explain:
SPEECH:	Normal: () Abnormal: () Remarks

DIAGNOSTIC RECOMMENDATIONS:		Please Check the Appropriate Recommendations:
<input type="checkbox"/> Psychiatric Diagnosis <input type="checkbox"/> Psychiatric Therapy <input type="checkbox"/> Psychological Diagnosis <input type="checkbox"/> Educational Referral <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Rehabilitation Referral <input type="checkbox"/> Surgery	<input type="checkbox"/> Orthopedics <input type="checkbox"/> ENT <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Neurology <input type="checkbox"/> Dentistry <input type="checkbox"/> EEG <input type="checkbox"/> EKG <input type="checkbox"/> Endocrine Tests <input type="checkbox"/> Other: _____	
LABORATORY REQUESTS AND/OR RESULTS:		
IMMUNIZATIONS GIVEN:		

Stamp or Print Physician Name/Address/Phone:

Physician's Signature: _____

Date:

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