

Physical Examination

Adriel, Inc.
22897 US 20-A
Archbold OH 43502
Phone: (419) 445-1980 Fax: (888) 820-8966

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:()
TM's:	Normal:() Red:() Bulging:() Retracted:()
CERNUM OBSTRUCTED:	Right: () Left:()
HEARING:	Normal:() Abnormal:() Remarks:
NOSE:	Normal:() Abnormal:() Remarks:
THROAT:	Normal:() Red:()
TONSILS:	Yes: () No: () Hypertrophied:()
ADENOPATHY:	Yes: () No: ()
ORAL HYGIENE:	Good: () Fair: () Poor: ()
NECK:	Normal:() Abnormal:() Remarks:
CHEST:	Normal:() Abnormal:() Remarks:
LUNGS:	Normal:() Abnormal:() Remarks:
HEART:	Normal:() Abnormal:()
MURMUR:	Yes: () No: () Type: 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:

Physical Examination

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:

Physical Examination

Page 2 of 2