



# INTENSITY FOOTBALL

## Contact Information/Health History

Name: \_\_\_\_\_  
 D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ (relationship): \_\_\_\_\_  
 Emergency Contact Address and phone #'s: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ PCP Phone #: \_\_\_\_\_  
 Primary Insurance Company: \_\_\_\_\_ Ins. Co. Phone: \_\_\_\_\_  
 Policy #, Group #, etc: \_\_\_\_\_

**Medical History:** Please complete and turn in to team Head Athletic Trainer

Yes	No	Explain "yes" answers at end of this table, circle questions you don't know answer to.
		1. Have you had medical illness or injury in the past year?
		2. Do you have any ongoing or chronic illness?
		3. Have you ever been hospitalized?
		4. Have you ever had surgery?
		5. Have you ever taken any supplements or vitamins to help improve your performance?
		6. Have you ever taken any medications (diet pills, laxatives, diuretics, etc) or supplements to help lose or gain weight?
		7. Do you smoke or chew tobacco? How much? _____ for how long? _____
		8. Do you have any allergies (to medicine, environment, or other?) Please list below:
		9. Have you ever passed out or been dizzy or lightheaded during or after exercise?
		10. Have you ever had chest pain or discomfort during or after exercise?
		11. Do you get tired more quickly or more short of breath than your friends do during exercise?
		12. Have you ever had racing of your heart or skipped heartbeats, or been diagnosed with an arrhythmia?
		13. Have you been diagnosed with (or take medication for) high blood pressure or high cholesterol? (which?)
		14. Do you have a heart murmur, or do you have to take antibiotics before having any dental work?
		15. Have you ever had Rheumatic Fever?
		16. Has any family member or relative died or been disabled by heart problems or sudden cardiac death before age 50?
		17. Have you or any family member or relative been diagnosed with Marfan's Syndrome?
		18. Have you or any family member or relative been diagnosed with Cardiomyopathy? (Hypertrophic or Dilated?)
		19. Have you or any family member or relative been diagnosed long QT syndrome or any cardiac arrhythmias?
		20. Have you had any significant viral illness/infection within the last 3 months? (e.g.- mononucleosis, myocarditis, etc)
		21. Has a physician ever denied or restricted your participation in sports for any heart problems?
		22. Has a physician ever denied or restricted your participation in sports for anything other than musculoskeletal injury?
		23. Do you have any current skin problems? (itching, rash, fungus, warts, blisters, acne, etc.)
		24. Do you have a history of any chronic or recurring skin problems?
		25. Have you ever had a head injury or concussion?
		26. Have you ever been knocked out, become unconscious, or lost your memory?
		27. Have you ever had a seizure?
		28. Do you have frequent or severe headaches?
		29. Have you ever been told that your pupils are usually/naturally of unequal size?



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Yes	No	Explain "yes" answers at end of this table, circle questions you don't know answer to.
		30. Have you ever had numbness or tingling in your arms, hands, legs, or feet?
		31. Have you ever had a stinger, burner, or pinched nerve?
		32. Have you ever become ill from exercising in the heat?
		33. Do you have asthma or cough, wheeze, or have trouble breathing during or after exercise?
		34. Do you have any seasonal allergies that require medical treatment?
		35. Do you use any special protective or corrective equipment or devices that aren't usually used/required for your sport?
		36. Have you had any problems with your eyes or vision?
		37. Do you wear glasses or corrective lenses when competing?
		38. Do you wear protective eyewear when competing?
		39. Are you missing or do you have malfunction of any body part? (eye, ear, kidney, lung, ovary, etc)
		40. Do you have toothaches, missing teeth, or dental appliances?
		41. Do you feel stressed out?
		42. Do you strive to lose or gain weight for the purposes of competition?
		43. Do you want to weigh more or less than you do now? If yes, current weight: _____ Target weight: _____
		44. In the past 3 years, approximately what was your highest weight? _____ Lowest weight? _____
		45. How long ago was your most recent menstrual period? _____
		46. Is your menstrual cycle regular? How much time do you usually have from one period to another? _____
		47. Indicate any sprains (sp), strains (st) fractures (fx) dislocations (ds) or other (oth) injuries you've sustained to your: Head _____ Neck _____ Chest _____ Back _____ Abdomen/Pelvis _____ Shoulder _____ Upper Arm _____ Elbow _____ Forearm _____ Wrist/Hand _____ Knee _____ Hip _____ Groin/Thigh _____ Knee _____ Shin/Calf _____ Ankle/Foot _____ Describe any orthopedic injuries more completely in the space below

Explain any "Yes" answers here, indicating the # of the question you're explaining: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Medications** (include prescription, prescriber, dosages, and OTC meds): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

By signing below, I indicate and understand that:

- 1) To the best of my knowledge, my answers to the above questions are complete and true.
- 2) I know of no reason why I should not be able to participate fully in full contact tackle football.
- 3) If anything in my health status changes, I will report it immediately to the Intensity's Athletic Trainer and may be referred by him/her for further necessary medical treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_