Date of Exam: _____

Name: _____ DOB: _____ Age: _____

Address: _____

Weight: _____ Height: _____ Blood Pressure: _____

Spines & Joints: _____

Feet: _____ Right: _____ Left: _____

Abdomen: _____ Hernia: _____

Posture: _____ Nutrition: _____

Deformities: _____

Skin: _____ Infection: _____ Scars: _____ Jaundice: _____ Purpura: _____

Visual Activity: _____ Eyeglasses: _____ Contact Lenses: _____

Ears: _____ Acute or Chronic Infection: _____ Hearing: _____ Eardrum: _____

Nose: _____ Deformity: _____ Throat: _____

Neck: _____ Range of Motion: _____ Pain: _____

Teeth & Gums: _____ Tonsils: _____ Adenoids: _____ Thyroid: _____

Chest Contour: _____ Heart: _____ Lungs: _____

Reflexes: _____ Balance: _____ Coordination: _____

Physiological Maturation: _____

Mantoux TB Test: Tested on: _____ Read: _____ Results (mm): _____

Physical Limitations? (if any) _____

Any Medications? (dosage/times)_____

Name of Physician: _____ Signature: _____