SAINT LOUIS
SPORTS MEDICINE

Dear Tryout Participant:

On behalf of the Sports Medicine Department, we look forward to working with you during the tryout process. Please review this letter to understand what is required and complete the needed medical documentation. Please submit all of this information to the athletic training staff several days **prior** to your tryout. Physical examinations are required for all tryout participants for intercollegiate athletic teams at Saint Louis University. These physicals must be within 12 months of the tryout date from a licensed physician.

Please submit:

- **Physical Exam within 12 months** (For participants still in high school, a clear to participate note from a physician of your choice will be accepted.)
- **Acknowledgment of Insurance Requirements**
- **Provide a copy of your current insurance cards**
- **Student/Family Information Form**
- **Student-Athlete Health History Questionnaire**
- **Authorization for Release of Protected Health Information**

All costs related to pre-participation physicals are the full financial responsibility of the tryout student-athlete, including any additional charges generated from supplemental tests. **THERE ARE NO EXCEPTIONS TO THIS POLICY.**

Saint Louis University Student Health Center provides opportunities to receive a physical examination on campus by our team physician. Please contact the Student Health Center at 314-977-2323, to schedule your appointment. The Student Health Center accepts most insurance plans.

All medical records on file in the athletic training room become confidential property of Saint Louis University Athletics Department and cannot be used for non-athletic purposes. Should you develop a significant injury or illness after your physical examination, but before the tryout practice, you must present to the Saint Louis University athletic training staff a letter from a qualified physician stating you are eligible to be cleared.

Thanks for your time and effort. If you have any questions please feel free to contact me at jonathan.burch@slu.edu.

Please return all paperwork to:

Jonathan Burch, ATC
Assistant Athletic Director / Sports Medicine
jonathan.burch@slu.edu

SAINT LOUIS
SPORTS MEDICINE

ACKNOWLEDGMENT OF INSURANCE REQUIREMENTS

I _____ as parent, guardian or legal representative, attest that
(name, please print)

_____ has insurance coverage under a current, in force insurance
(student-athlete name)

policy for injuries that occur while he/she is participating in intercollegiate athletics. This coverage has limits of at least $90,000.

If there is a material change in coverage or expiration of coverage, I agree to notify Saint Louis University of this development and update the insurance information I have on file with Saint Louis University.

I understand and agree that Saint Louis University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses if I/we fail to have this primary insurance coverage.

Signature _____ Date _____
(policy holder)

THIS FORM MUST BE PRINTED, SIGNED AND RETURNED TO THE SAINT LOUIS DEPARTMENT OF ATHLETICS

A COPY OF YOUR CURRENT INSURANCE CARD (FRONT AND BACK) IS REQUIRED

Return to:

Saint Louis University
3330 Laclede Avenue
St. Louis, MO 63103

Phone: 314-977-3295
Fax: 314-977-3183

SAINT LOUIS
SPORTS MEDICINE

STUDENT/FAMILY INFORMATION FORM

IMPORTANT NOTICE: The student accident insurance plan is designed to offer maximum financial protection at minimum cost. In order to maintain this balance of cost and adequate protection, the plan does not allow us to provide benefits for certain losses that are collectible from other insurance. This provision greatly reduces costs by not duplicating coverage that you already have in effect. Please attach a copy of your insurance card to this form.

School **Saint Louis University** Address **3330 Laclede Avenue, St. Louis, MO 63103** Phone **314-977-3295**

Student _____ Sport _____
Last Name First Name Middle Initial

Banner ID # _____ Sex ☐ F ☐ M Birth date _____

School Address _____ City/State/Zip _____

Home Address _____ City/State/Zip _____

School Phone _____ Home Phone _____

EMERGENCY CONTACT

Name _____ **Home Phone** _____ **Cell Phone** _____

ALL SAINT LOUIS UNIVERSITY STUDENTS MUST HAVE PRIMARY HEALTH INSURANCE

Father's Name _____

Father's Address (☐ same as above) _____

_____

City/State/Zip _____

Father's Employer _____

Business Phone _____

Employer's Address _____

City/State/Zip _____

Name and Address of Insurance Company

_____

_____

City/State/Zip _____

Policy Number _____

Company Phone _____

Is the student covered?..... ☐ YES ☐ NO

Primary Physician Name _____

Primary Physician Phone _____

Provider Number _____

Is pre-certification required for treatment? ..... ☐ YES ☐ NO

Is pre-certification required for hospitalization? ..... ☐ YES ☐ NO

Mother's Name _____

Mother's Address (☐ same as above) _____

_____

City/State/Zip _____

Mother's Employer _____

Business Phone _____

Employer's Address _____

City/State/Zip _____

Name and Address of Insurance Company

_____

_____

City/State/Zip _____

Policy Number _____

Company Phone _____

Is the student covered?..... ☐ YES ☐ NO

Primary Physician Name _____

Primary Physician Phone _____

Provider Number _____

Is pre-certification required for treatment? ..... ☐ YES ☐ NO

Is pre-certification required for hospitalization? ..... ☐ YES ☐ NO

Do you understand that you must furnish, with claims, a statement from your other insurance company indicating their allowable benefits or their reason for refusal to pay? Your claims may be held pending receipt of this information ..... ☐ YES ☐ NO

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the student's health, to give information to the insurance company. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. I understand that false or incomplete claim information will prolong claim benefit determination. A photocopy of this authorization shall be as valid as the original.

_____ _____

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE
PARENT/GUARDIAN SIGNATURE IF UNDER 18 YEARS OF AGE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

SAINT LOUIS
SPORTS MEDICINE

HEALTH HISTORY QUESTIONNAIRE

Name _____ Sex ☐ F ☐ M Age _____ Birth date _____

Banner ID# _____ Sport _____

Local address _____ Local phone _____

Permanent address:

Street _____ City / State / Zip _____

Phone _____ Cell phone _____

Email address _____

Father's name _____ Age _____

If deceased, cause of death _____ Age @ death _____

Father's occupation _____

Address (if different from permanent address):

Street _____ City / State / Zip _____

Home phone _____ Work phone _____

Mother's Name _____ Age _____

If deceased, cause of death _____ Age @ death _____

Mother's occupation _____

Address (if different from permanent address):

Street _____ City / State / Zip _____

Home phone _____ Work phone _____

IN CASE OF EMERGENCY, CONTACT: Name _____

Relationship _____ Phone (h) _____ Phone (w/c) _____

Personal Physician _____ Physician phone _____

Have any of your relatives had:

			RELATIONSHIP				RELATIONSHIP
• Asthma	☐ YES	☐ NO	_____	• Heart Disease	☐ YES	☐ NO	_____
• Arthritis	☐ YES	☐ NO	_____	• Kidney Disease	☐ YES	☐ NO	_____
• Cancer	☐ YES	☐ NO	_____	• Stomach Trouble	☐ YES	☐ NO	_____
• Diabetes	☐ YES	☐ NO	_____	• Stroke	☐ YES	☐ NO	_____
• Epilepsy	☐ YES	☐ NO	_____	• Tuberculosis	☐ YES	☐ NO	_____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

1. CARDIOVASCULAR RISK FACTORS

Have you ever had chest pain, dizziness, fainting and/or shortness of breath during or after exercise / practice? ☐ YES ☐ NO

- Please describe _____

Have you ever been told that you have a heart murmur? ☐ YES ☐ NO

- Please describe _____

Does anyone in your family have Marfan Syndrome? ☐ YES ☐ NO

- Please describe _____

Has any family member or relative died of heart problems and/or of sudden death before age 50? ☐ YES ☐ NO

- Please describe _____

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? ☐ YES ☐ NO

- Please describe _____

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? ☐ YES ☐ NO

- Dates / please describe _____

Do you or anyone in your family have a history of high blood pressure? ☐ YES ☐ NO

- Please describe _____

Do you or anyone in your family have a history of high blood cholesterol? ☐ YES ☐ NO

- Please describe _____

2. ALLERGIES

Have you ever been diagnosed with any allergies or had any unfavorable reactions to foods, insects and/or drugs? ☐ YES ☐ NO

- Please describe _____

Are you presently taking / have you previously taken any allergy medications? ☐ YES ☐ NO

- Please describe _____

Have you ever had a rash or hives develop during and/or after exercise? ☐ YES ☐ NO

Do you cough, wheeze, have chest tightness, have shortness of breath, or have trouble breathing during or after exercise / practice, at night, or after exposure to allergens / pollutants? ☐ YES ☐ NO

Have you ever been prescribed an epi pen? ☐ YES ☐ NO

3. ASTHMA

Have you ever been diagnosed with asthma and/or exercised induced asthma? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Are you presently taking / have you previously taken any asthma medications / use an inhaler? ☐ YES ☐ NO

- Date(s)? Type of medication _____

Have you ever been advised not to participate in athletic activities due to asthma or any related condition? ☐ YES ☐ NO

- Please describe _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

4. HEAD INJURIES / CONCUSSION

Have you ever suffered a head injury / concussion (no matter how minor)? ☐ YES ☐ NO

- Please describe (include dates and details): _____

Have you ever been evaluated by a doctor for a head injury / concussion? ☐ YES ☐ NO

- Please describe _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan

Have you ever been hospitalized, knocked out, and/or suffered memory loss to a head injury / concussion? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a head injury / concussion? ☐ YES ☐ NO

- Please describe _____

5. EYE

Do you have any problems with your vision? ☐ YES ☐ NO

- Please describe _____

When was your last eye exam? _____

- Findings? _____

Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease? ☐ YES ☐ NO

- List date(s) / time (e.g. practices or games) missed _____

Do you routinely wear glasses and/or contact lenses? ☐ YES ☐ NO

6. EAR / NOSE / THROAT

Have you ever suffered an injury to your ear(s), nose and/or throat? ☐ YES ☐ NO

- Please explain and list date(s) / time (e.g. practices or games) missed _____
- Were any diagnostic tests performed? ☐ YES ☐ NO If yes, please list _____

Have you ever been hospitalized for an ear, nose, and/or throat injury? ☐ YES ☐ NO

Have you ever been advised not to participate in athletic activities due to an ear, nose, and/or throat injury? ☐ YES ☐ NO

- Please describe _____

7. DENTAL

When was your last dental exam? _____

- Findings? _____

Have you ever suffered an injury to your mouth, jaw, and/or teeth? ☐ YES ☐ NO

- Please explain and list date(s) / time (e.g. practices or games) missed _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

8. CERVICAL SPINE / NECK

Have you ever suffered an injury to your cervical spine and/or neck? ☐ YES ☐ NO

- Please explain and list date(s) / time (e.g. practices or games) missed _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a cervical spine / neck injury? ☐ YES ☐ NO

- Please describe (include location and date): _____

Have you ever had "numbness," "tingling," "burners," "stingers," or brachial plexus injuries? ☐ YES ☐ NO

- How many? Date(s)/time missed? _____

Have you ever been advised not to participate in athletic activities due to a cervical spine / neck injury? ☐ YES ☐ NO

- Please describe _____

9. SHOULDER / ARM / ELBOW / WRIST / HAND

Have you ever suffered an injury to your shoulder / arm / elbow / wrist / hand? ☐ YES ☐ NO

- Please explain and list date(s) / time (e.g. practices or games) missed _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery of any kind on your shoulder / arm / elbow / wrist / hand? ☐ YES ☐ NO

- Please describe (include dates and details): _____

Have you ever been advised not to participate in athletic activities due to a shoulder / arm / elbow / wrist / hand injury? ☐ YES ☐ NO

- Please describe _____

10. SPINE / LOW BACK / SACROILIAC JOINT

Have you ever suffered an injury to your spine / low back / sacroiliac joint? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery of any kind on your spine / low back / sacroiliac joint? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a spine, low back, or SI joint injury? ☐ YES ☐ NO

- Please describe _____

11. HIP / GROIN

Have you ever suffered an injury to your hip / groin (including hernias and/or sports hernias)? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery for a hip / groin injury? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a hip and/or groin injury? ☐ YES ☐ NO

- Please describe _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

12. THIGH / HAMSTRING / QUADRICEPS

Have you ever suffered an injury to your thigh, hamstring, and/or quadriceps? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been advised not to participate in athletic activities due to a thigh, hamstring, or quadriceps injury? ☐ YES ☐ NO

- Please describe _____

13. KNEE / PATELLA

Have you ever suffered an injury to your knee and/or patella (kneecap)? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery for a knee and/or patella injury? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a knee / patella injury? ☐ YES ☐ NO

- Please describe _____

14. ANKLE / LOWER LEG / FOOT

Have you ever suffered an injury to your ankle / lower leg or foot? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (Check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery for an ankle / lower leg / foot injury? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to an ankle / lower leg / foot injury? ☐ YES ☐ NO

15. ABDOMEN / RIBS / THORAX / CHEST

Have you ever suffered an injury to your abdomen / rib / thorax / chest? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (Check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery for a rib / thorax / chest injury? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a ribs, thorax, and/or chest injury? ☐ YES ☐ NO

- Please describe _____

16. MEDICAL TESTING

Have you ever been diagnosed with a Communicable Disease
(e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis)? ☐ YES ☐ NO

- Please describe _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

17. DERMATOLOGICAL (SKIN)

Do you have any skin problems that we should be aware of
(e.g. ringworm, herpes, skin infection, itching, rashes, acne, warts, eczema, fungus, etc.)? ☐ YES ☐ NO

- Please describe _____

Have you ever been diagnosed with a staph infection and/or MRSA infection on any part of your body? ☐ YES ☐ NO

- Please describe _____

Have you ever been under the care of a dermatologist for any condition? ☐ YES ☐ NO

18. PRESCRIPTION MEDICATIONS

Please list ALL Prescription & Over-the-Counter Medications that you are CURRENTLY taking or have taken in the past 2 years, and for what purpose:

MEDICATION	PURPOSE	DOSAGE	DATE(S)

19. SUPPLEMENTS / ERGOGENIC AIDS

Please list ALL supplements / ergogenic aids that you are CURRENTLY taking or have taken in the PAST 2 years, and for what purpose:

SUPPLEMENT	PURPOSE	DOSAGE	DATE(S)

☐ YES ☐ NO I have taken supplements to help me gain or lose weight.

20. HEAT RELATED PROBLEMS

Have you ever suffered from a heat related injury? ☐ YES ☐ NO

(check all that apply):

☐ YES ☐ NO Heat Cramps Date(s) _____

☐ YES ☐ NO Heat Syncope (Fainting) Date(s) _____

☐ YES ☐ NO Heat Exhaustion Date(s) _____

☐ YES ☐ NO Heat Stroke Date(s) _____

Have you ever been hospitalized for a heat-related problem? ☐ YES ☐ NO

- Date(s)? Where? _____

Have you ever been advised not to participate in athletic activities due to a heat related injury? ☐ YES ☐ NO

- Please Describe _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

21. DIABETIC HISTORY

Have you ever been diagnosed with Diabetes? ☐ YES ☐ NO

- Date? _____

Are you presently taking or have you taken any Diabetic medications? ☐ YES ☐ NO

MEDICATION	FORM	DOSAGE	FREQUENCY

Please list any precautions that you take and/or additional information not mentioned above _____

_____

22. SICKLE CELL ANEMIA

Have you ever been tested for Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO ☐ DON'T KNOW

- Date? Result? _____

The NCAA recommends that all student athletes be aware of their sickle cell status. If you checked "don't know" above, please review the attached Sickle Cell Information Sheet, and arrange for sickle trait testing.

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Please Describe _____

23. FEMALES ONLY

At what age did you have your first menstrual period? _____When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of the next? _____

☐ YES ☐ NO Has your menstrual period changed appearance within the past 6 months? _____

What was the longest time between periods in the past year? _____

☐ YES ☐ NO Have you had menstrual periods within the past 12 months? If yes, how many? _____

☐ YES ☐ NO Do you take birth control pills? Brand _____

☐ YES ☐ NO Do you take any medications during your menstrual periods? If yes, what? _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

24. MENTAL HEALTH

SECTION 1

I often have trouble sleeping.	☐ YES	☐ NO
I wish I had more energy most days of the week.	☐ YES	☐ NO
I think about things over and over.	☐ YES	☐ NO
I feel anxious and nervous much of the time.	☐ YES	☐ NO
I often feel sad or depressed.	☐ YES	☐ NO
I struggle with being confident.	☐ YES	☐ NO
I don't feel hopeful about the future.	☐ YES	☐ NO
I have a hard time managing my emotions (frustration, anger, impatience).	☐ YES	☐ NO
I have feelings of hurting myself or others.	☐ YES	☐ NO

SECTION 2

Do you make yourself sick because you feel uncomfortably full?	☐ YES	☐ NO
Do you worry that you have lost control over how much you eat?	☐ YES	☐ NO
Have you recently lost more than 15 pounds in a 3-month period?	☐ YES	☐ NO
Do you believe yourself to be fat when others say you are thin?	☐ YES	☐ NO
Would you say food dominates your life?	☐ YES	☐ NO

SECTION 3

Please answer using the following scale:
0=None or a little of the time; **1**=Some of the time;
2=Most of the time; **3**=All of the time

Over the past two weeks, how often have you:

Been feeling low in energy, slowed down?	☐ 0	☐ 1	☐ 2	☐ 3
Blamed yourself for things?	☐ 0	☐ 1	☐ 2	☐ 3
Had poor appetite?	☐ 0	☐ 1	☐ 2	☐ 3
Had difficulty falling asleep, staying awake?	☐ 0	☐ 1	☐ 2	☐ 3
Been feeling hopeless about the future?	☐ 0	☐ 1	☐ 2	☐ 3
Been feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3
Had feelings of no interest in things?	☐ 0	☐ 1	☐ 2	☐ 3
Had feelings of worthlessness?	☐ 0	☐ 1	☐ 2	☐ 3
Thought about or wanted to commit suicide?	☐ 0	☐ 1	☐ 2	☐ 3
Had difficulty concentrating or making decisions?	☐ 0	☐ 1	☐ 2	☐ 3

SECTION 4

Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by indicating the response option using:
0=not at all; **1**=mildly but it didn't bother me much;
2=moderately – it wasn't pleasant at times;
3=severely – it bothered me a lot

Numbness or tingling	☐ 0	☐ 1	☐ 2	☐ 3
Feeling hot	☐ 0	☐ 1	☐ 2	☐ 3
Wobbliness in legs	☐ 0	☐ 1	☐ 2	☐ 3
Unable to relax	☐ 0	☐ 1	☐ 2	☐ 3
Fear of worst happening	☐ 0	☐ 1	☐ 2	☐ 3
Dizzy or lightheaded	☐ 0	☐ 1	☐ 2	☐ 3
Heart pounding/racing	☐ 0	☐ 1	☐ 2	☐ 3
Unsteady	☐ 0	☐ 1	☐ 2	☐ 3
Terrified or afraid	☐ 0	☐ 1	☐ 2	☐ 3
Nervous	☐ 0	☐ 1	☐ 2	☐ 3
Feeling of choking	☐ 0	☐ 1	☐ 2	☐ 3
Hands trembling	☐ 0	☐ 1	☐ 2	☐ 3
Shaky/unsteady	☐ 0	☐ 1	☐ 2	☐ 3
Fear of losing control	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty in breathing	☐ 0	☐ 1	☐ 2	☐ 3
Fear of dying	☐ 0	☐ 1	☐ 2	☐ 3
Scared	☐ 0	☐ 1	☐ 2	☐ 3
Indigestion	☐ 0	☐ 1	☐ 2	☐ 3
Faint/lightheaded	☐ 0	☐ 1	☐ 2	☐ 3
Face flushed	☐ 0	☐ 1	☐ 2	☐ 3
Hot/cold sweats	☐ 0	☐ 1	☐ 2	☐ 3

SECTION 5

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	☐ YES	☐ NO
Do you often feel tired, fatigued, or sleepy during daytime?	☐ YES	☐ NO
Has anyone observed you stop breathing during your sleep?	☐ YES	☐ NO
Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

24. MENTAL HEALTH (CONTINUED)

SECTION 6

Please rate the current (i.e. last 2 weeks) **severity** of your insomnia problem(s).

Difficulty falling asleep	☐ none	☐ mild	☐ moderate	☐ severe	☐ very
Difficulty staying asleep	☐ none	☐ mild	☐ moderate	☐ severe	☐ very
Problem waking up too early	☐ none	☐ mild	☐ moderate	☐ severe	☐ very
How **satisfied**/disappointed are you with your current sleep pattern?			☐ very satisfied	☐ very dissatisfied	

To what extent do you consider your sleep problems to **interfere** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?	☐ not at all interfering	☐ a little	☐ somewhat	☐ much	☐ very much interfering
How **noticeable** to others do you think your sleeping problem is in terms of impairing the quality of your life?	☐ not at all noticeable	☐ a little	☐ somewhat	☐ much	☐ very much noticeable
How **worried**/distressed are you about your current sleep problem?	☐ not at all	☐ a little	☐ somewhat	☐ much	☐ very much

SECTION 7

Select the response option that best describes how you have felt and conducted yourself over the past 6 months.

1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
3. How often do you have problems remembering appointments or obligations?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
6. How often do you feel overly active and compelled to do things like you were driven by a motor?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

25. HEALTH HISTORY

☐ YES ☐ NO Have you had an injury in the last year that has caused you to miss 3 or more consecutive days of practice/competition?
☐ YES ☐ NO Have you ever had any injury or illness other than those already noted?
☐ YES ☐ NO Do you have any ongoing or chronic illnesses?
☐ YES ☐ NO Do you have only one of any paired organs (eyes, kidneys, testicles, ovaries)?
☐ YES ☐ NO Have you ever been hospitalized overnight?
☐ YES ☐ NO Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?
☐ YES ☐ NO Are you currently under a physician's care for any medical conditions?
☐ YES ☐ NO Have you ever been diagnosed or are you currently under physician care for ADHD or ADD?
☐ YES ☐ NO Are you currently taking any medications to treat ADHD or ADD?
☐ YES ☐ NO Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years? (Circle all that apply.)
☐ YES ☐ NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
☐ YES ☐ NO Have you ever had seizures, convulsions, and/or epilepsy?
☐ YES ☐ NO Do you have frequent, severe (migraine) headaches?
☐ YES ☐ NO Do you have ringing in your ears or trouble hearing?
☐ YES ☐ NO Have you ever had an abnormal chest x-ray and/or pneumonia?
☐ YES ☐ NO Do you require any special equipment (braces, dental, orthotics, hearing aids, etc.)?_____
☐ YES ☐ NO Have you ever had the chickenpox? If yes, when? _____
☐ YES ☐ NO Have you had a tetanus booster within the past five (5) years? If yes, when? _____
☐ YES ☐ NO Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? _____
☐ YES ☐ NO I have tried cigarettes, chewing tobacco, snuff, or dip.
☐ YES ☐ NO In the past 30 days, I have used chewing tobacco, snuff, or dip.
☐ YES ☐ NO Do you have any questions regarding drugs, tobacco, or alcohol?
☐ YES ☐ NO Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
☐ YES ☐ NO Are you a vegetarian or on a gluten-free diet? If yes, what type?_____
☐ YES ☐ NO Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
☐ YES ☐ NO Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?
☐ YES ☐ NO I have taken performance enhancing substances (including anabolic steroids).
☐ YES ☐ NO Are you aware of any reasons why you should not participate in intercollegiate athletics at Saint Louis University at this time?_____
☐ YES ☐ NO Would you like to see the team physician in private, for any reason? (You will not be asked to explain.)

Please explain all "yes" answers:

_____

_____

_____

_____

_____

_____

_____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

CONSENT FOR TREATMENT & RELEASE OF MEDICAL INFORMATION

I hereby authorize the members of the Saint Louis University sports medicine department, its physicians and designees to treat any injury or illness that affects my ability to participate in athletic activities at Saint Louis University. I consent to the release of my medical records and related information to Saint Louis University personnel for use in connection with diagnosis, treatment, and/or rehabilitation of such injuries or illness and for determinations of fitness to return to play. This authorization shall expire at the end of the current academic year and/or the end of competitive season, whichever should come later in time.

I verify that all the information is accurate and complete. I understand that failure to disclose previous medical conditions may result in a medical disqualification. I understand that Saint Louis University is not responsible for expenses related to any previously existing conditions.

_____ _____

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

_____

PRINT NAME

IF UNDER 18 YEARS OF AGE:

_____ _____

PARENT/GUARDIAN SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

_____

PRINT NAME

PARENTAL CONSENT

The law requires, with certain exceptions, that parental permission be obtained for operative and therapeutic procedures on minors. The following consent form must be signed by the parent or legal guardian, so that medical or emergency procedures can be carried out promptly, reducing unnecessary delay and discomfort. I give my permission for such medical procedures as may be deemed necessary for my son/daughter.

_____ _____

NAME OF STUDENT DATE

_____ _____

PARENT/GUARDIAN SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) RELATIONSHIP TO STUDENT

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

_____ _____

PHONE (HOME) PHONE (WORK/CELL)

_____ _____

ATHLETIC TRAINER SIGNATURE DATE

SAINT LOUIS
SPORTS MEDICINE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Student-Athlete Name _____
First Middle Initial Last

Date of Birth _____ Age _____ Student ID# _____ Sport _____

1. I hereby acknowledge that I received a copy of the Saint Louis University Notice of Privacy Practices.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

2. I hereby grant permission to the Sports Medicine Staff of Saint Louis University Department of Athletics to release health information pertaining to my fitness to participate in SLU Intercollegiate Athletic activities to Athletic Department administrators, coaches, and administrative staff responsible for assessing or approving my participation to the extent the information is needed for that purpose.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

3. I hereby grant permission to SLU Department of Athletics administrators and coaches to release to the news media the nature of any athletic-related injury or illness and my expected rehabilitation period, if any, for purposes of addressing my participation in intercollegiate athletic activities. This information may also be released to my parent or guardian.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

4. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Director of Athletics. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that SLU Department of Athletics may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

   I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize SLU to fax the information, I realize there are inherent risks in faxing Protected Health Information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

EACH AUTHORIZATION EXPIRES ONE CALENDAR YEAR FROM SIGNATURE DATE.