

COMPETITIVE SCREENING QUESTIONNAIRE



The information you provide in this questionnaire will be used to assess whether you are at risk of injury and, in case of injury, to contact your next of kin. It is confidential and will not be shown to anyone except the team coaching staff.

1 PERSONAL DETAILS

Name: _____
First Last

Address: _____

Telephone: _____ Mobile: _____

Email: _____

Date of birth: ____/____/____
Day Month Year

Date this form was completed: ____/____/____
Day Month Year

2 NEXT OF KIN (EMERGENCY PURPOSES ONLY)

Name: _____

Address: _____

Telephone: _____ Mobile: _____

Relationship: _____

3 HEALTH HISTORY

Do you have any medical condition(s)/disability?
 If the answer is "yes", please list the condition and any medication you take for it.

Condition/disability <i>eg. asthma, heart disease, diabetes, epilepsy, HIV, anaemia, haemophilia, arthritis, viral illness, hepatitis A, B or C</i>	Medication <i>eg. tablets, inhalers, creams (give drug names)</i>	Frequency <i>eg. twice daily, only with symptoms</i>

Allergies <i>eg. bee stings</i>	Medication <i>eg. tablets, inhalers, creams (give drug names)</i>	Dose/frequency

COMPETITIVE SCREENING QUESTIONNAIRE *Continued...*

4 INJURY HISTORY

List any injuries you have had in the past three years and when they happened (eg. concussion, fracture, sprains, strains). List the treatment you had and who gave you the treatment eg. doctor/coach/physiotherapist.

What was the injury? <i>eg. sprained ankle</i>	When did it happen? <i>eg. 11 July 2002</i>	What treatment did you get? <i>eg. R.I.C.E.D. on crutches for a while and then sessions with physiotherapist</i>	Who provided the treatment? <i>eg. physiotherapist</i>	Current status of the injury? <i>eg. fully recovered or not</i>

5 LIFESTYLE ASSESSMENT

What does your main activity/occupation involve?

- Sedentary *eg. desk job, study*
 Light physical work *eg. home maintenance, sales representative*
 Heavy physical work *eg. courier, tradesperson*

How many hours do you spend at that activity/occupation a week? _ _ _ . _

Do you have reliable transport to and from training and games? Yes No

What other sports/commitments do you have? _____

Do you have the appropriate protective equipment for this sport *eg. mouthguard, helmet?* Yes No

6 PHYSICAL ASSESSMENT (FOR COACH/TRAINER TO COMPLETE)

Height in cm: _ _ _ _ Weight in kg: _ _ _ . _

Aerobic endurance	Beep test score:	
	3km time run:	
Speed	Time for 50m sprint:	
Speed and agility	Time for propeller test:	
Upper body strength	Number of press-ups:	
	Number of chin-ups:	
Other		

Flexibility	Good	Average	Poor	Balance	Left leg	Right leg
Hamstrings				Time for single leg balance – eyes open:		
Lower back				Time for single leg balance – eyes closed:		
Shoulder				Time for single leg balance – eyes closed and head tilted back:		

7 Player's signature _____

Assessor's signature _____

Follow-up date: _ _ / _ _ / _ _
Day Month Year