MASTERS 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 organiser.

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 *eg. asthma, heart disease, diabetes, epilespy, HIV, anaemia, arthritis, haemophilia, viral illness, hepatitis A, B or C*	Medication *eg. tablets, inhalers, creams (give drug names)*	Frequency *eg, twice daily, only with symptoms*

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

ACC SPORTSMART

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

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 each week? ___ ___ • ___

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

How many sports/recreational activities do you do each week? ______________________

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

6 PHYSICAL ASSESSMENT – ONLY FOR REPRESENTATIVE LEVEL (FOR COACH/TRAINER TO COMPLETE)

Height in cm: ___ ___ ___ Weight in kg: ___ ___ ___ • ___

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

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