

## Initial Exam / Follow up

Name: _____	Date of Birth: _____
Height: _____ Weight: _____	Pulse: _____ BP: _____

History			
Chief Complaint			
Medical	Normal	Abnormal Findings	Initials*
<b>Heart*</b>			
<b>Lungs*</b>			
<b>Abdomen*</b>			
<b>Ankles /Edema*</b>			
Foot			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/ Oropharynx			
Lymph Nodes			
Pulses			
Neck			
Back			
Shoulder/Arm			
Elbow/ Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			

All bold and \* must be completed in both intial and follow up visit

Medically Cleared: YES _____ NO _____	
Name of physician (print/type) _____	Date _____
Address _____	Phone _____
Signature of physician _____	MD/DO/NP/PA-C
FAX COMPLETED FORM TO: 866-624-7650	