USA CLIMBING PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.
Name:_____Date of Birth: _____
Date of examination:_____
Sex assigned at birth (F, M, or intersex):_____How do you identify your gender? (F, M, or other): _____

Have you had COVID-19? (check one): ☐ Y ☐ N Date of COVID-19 diagnosis: _____

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N ***All athletes traveling to World Cups will need to submit proof of vaccination.***
If yes, have you had:☐ One shot ☐ Two shots ☐ Three shots ☐ Booster Date(s) of each shot: _____

Date of last tetanus vaccination: _____

List past and current medical conditions: _____

_____

Have you ever had surgery? If yes, list all past surgical procedures: _____

_____

Have you been hospitalized? ☐ Y ☐ N Reason for hospitalization: _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional), including those for allergies. Include all oral, inhaled, topical, injected or infused medications: _____

_____

_____

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

_____

_____

Do you take any medications for your allergies, either prescribed or over the counter? ☐ Y ☐ N

Do you have a history of anaphylaxis or use of injectable epinephrine? ☐ Y ☐ N

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	**YES**	**NO**
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have an ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems such as high blood pressure, high cholesterol, heart murmur, heart infection or Kawasaki's disease?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE and JOINT QUESTIONS	YES	NO
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or competition?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
16. Do you currently have a finger injury that bothers you?		
MEDICAL QUESTIONS	**YES**	**NO**
17. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
18. Are you missing a kidney, eye, a testicle (males), your spleen, or any other organ?		
19. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20. Do you have any recurring skin rashes or rashes that come and go, including herpes ormethicillin-resistant *Staphylococcus aureus* (MRSA)?		
21. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22. Have you ever had numbness, tingling, or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
23. Have you ever become ill while exercising in the heat?		
24. Do you or does someone in your family have sickle cell trait or disease?		
25. Have you ever had or do you have any problems with your eyes or vision?		
26. Do you worry about your weight?		
27. Are you trying to or has anyone recommended that you gain or lose weight?		
28. Are you on a special diet or do you avoid certain types of foods or food groups?		
29. Have you ever had an eating disorder?		
FEMALES ONLY	**YES**	**NO**
30. Have you ever had a menstrual period?		
31. How old were you when you had your first menstrual period?		
32. When was your most recent menstrual period?		
33. How many periods have you had in the past 12 months?		
34. Do you have any significant complications with your periods (cramps or other issues that require medication or missing school or work)?		

Explain "Yes" answers here

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian if under 18: _____

Date: _____

SMHAT-1

The International Olympic Committee Sport Mental Health Assessment Tool 1

DEVELOPED BY THE IOC MENTAL HEALTH WORKING GROUP

Athlete's name:_____ Athlete's ID number: _____

1

ATHLETE'S FORM 1

These questions concern how you have been feeling over the past 30 days. Please circle the answer that best represents how you have been.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. It was difficult to be around teammates	1	2	3	4	5
2. I found it difficult to do what I needed to do	1	2	3	4	5
3. I was less motivated	1	2	3	4	5
4. I was irritable, angry or aggressive	1	2	3	4	5
5. I could not stop worrying about injury or my performance	1	2	3	4	5
6. I found training more stressful	1	2	3	4	5
7. I found it hard to cope with selection pressures	1	2	3	4	5
8. I worried about life after sport	1	2	3	4	5
9. I needed alcohol or other substances to relax	1	2	3	4	5
10. I took unusual risks off-field	1	2	3	4	5

SMHAT-1

The International Olympic Committee Sport Mental Health Assessment Tool 1

DEVELOPED BY THE IOC MENTAL HEALTH WORKING GROUP

ATHLETE'S FORM 2

Screening 1

The following questions relate to feeling anxious or stressed. Over the last 2 weeks, how often have you been bothered by the following problems? Please circle the answer that best represents how you have been.

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Screening 2

The following questions relate to feeling depressed, sad or blue. Over the past 2 weeks, how often have you been bothered by any of the following problems? Please circle the answer that best represents how you have been.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Screening 3

The following questions relate to your sleep habits. Please circle the best answer which you think represents your typical sleep habits over the recent past.

1. During the recent past, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

5 to 6 hours	4
6 to 7 hours	3
7 to 8 hours	2
8 to 9 hours	1
more than 9 hours	0

2. How satisfied / dissatisfied are you with the quality of your sleep?

very satisfied	0
somewhat satisfied	1
neither satisfied nor dissatisfied	2
somewhat dissatisfied	3
very dissatisfied	4

3. During the recent past, how long has it usually taken you to fall asleep each night?

15 minutes or less	0
16 – 30 minutes	1
31 – 60 minutes	2
longer than 60 minutes	3

4. How often do you have trouble staying asleep?

never	0
once or twice per week	1
three or four times per week	2
five to seven days per week	3

5. During the recent past, how often have you taken medicine to help you sleep (prescribed or over-the-counter)?

never	0
once or twice per week	1
three or four times per week	2
five to seven times per week	3

Screening 4

The following questions are about alcohol use. Please respond to each question by circling the number from '0' to '4' that represents your alcohol use.

1. How often do you have a drink containing alcohol?

Never	0
Monthly or less	1
2-4 times a month	2
2-3 times a week	3
4 or more times a week	4

2. How many standard drinks containing alcohol do you have on a typical day when you drink?

1 to 2	0
3 to 4	1
5 to 6	2
7 to 9	3
10 or more	4

3. How often do you have six or more drinks on one occasion?

Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

2

Screening 5

The following questions are about drug(s) use in the last 3 months. Please respond to each question by circling 'yes' or 'no'. When thinking about drug use consider legal ones like caffeine or nicotine, illicit/illegal drugs (including cannabis even if legal in your state/country) and prescription medications used in ways other than prescribed (i.e., higher dosages; different ways of taking them, i.e., crushing/sniffing, injecting). Do NOT include alcohol in these responses.

	Yes	No
1. In the last three months, have you felt you should cut down or stop using drugs?	1	0
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop using drugs?	1	0
3. In the last three months, have you felt guilty or bad about how much you use drugs?	1	0
4. In the last three months, have you been waking up wanting to use drugs?	1	0

In the last 3 months, which drug(s) or substance(s) listed below caused concerns or problems in your life? Concerns may include drug-related stress, depression. insomnia, financial strain, relationship conflict, heavy use/overdose, cravings, withdrawal, blackouts, flashbacks, fights, arrests, missed work, and/or medical problems like hepatitis, seizures or weight loss. Please circle all that apply.

None	Stimulants-nicotine	Hallucinogens (LSD; mushrooms)
Cannabis-marijuana	Stimulants-powder cocaine	Inhalants (volatile solvents)
Cannabis-oil	Stimulants-crack cocaine	Opioids-heroin
Cannabis-edibles	Stimulants-methamphetamine (meth)	Opioids-opium
Cannabis-synthetics (K2; Spice)	Stimulants-methylphenidate (ADD/ADHD medication)	Opioids-pain medications (e.g. oxycodone, hydrocodone)
Club Drugs (MDMA-ectasy; GHB)	Stimulants-amphetamine salts (ADD/ADHD medication)	Synthetic Cathinones (bath salts)
Stimulants-caffeine	Dissociative Drugs (Ketamine; PCP)	Other (specify)

Screening 6

The following questions are related to your eating habits and your thoughts about food, eating, your weight and your body image. Over the past 2 weeks, how often have you been bothered by any of the following problems? Please circle the answer that best represents how you have been.

	Always	Usually	Often	Sometimes	Rarely	Never
1. I feel extremely guilty after overeating	3	2	1	0	0	0
2. I am preoccupied with the desire to be thinner	3	2	1	0	0	0
3. I think that my stomach is too big	3	2	1	0	0	0
4. I feel satisfied with the shape of my body	0	0	0	1	2	3
5. My parents have expected excellence of me	3	2	1	0	0	0
6. As a child, I tried very hard to avoid disappointing my parents and teachers	3	2	1	0	0	0
7. Are you trying to lose weight now?					Yes	No
8. Have you tried to lose weight?					Yes	No
9. If yes, how many times have you tried to lose weight?				1-2 times	3-5 times	>5 times

USA CLIMBING PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of Birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION			
Height:	Weight:		BMI:
BP: / (/)	Pulse:	Vision: R 20/ L 20/	Corrected: ☐Y ☐N

COVID-19 VACCINE

Previously received COVID-19 vaccine: ☐ Y ☐ N

If yes, ☐ First dose ☐ Second dose ☐Third dose ☐Booster Dates of each dose:_____

Administered COVID-19 vaccine at this visit: ☐Y ☐N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance: • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes, ears, nose, and throat: • Pupils equal • Hearing		
Lymph Nodes		
Heart: • Murmurs (auscultation standing, auscultation supine, and ± Valsava maneuver)		
Lungs		
Abdomen		
Skin : • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA) or tinea corporis		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional : • Double-leg squat, single-leg squat test, and box-drop or step-drop test		

Consider electrocardiography (ECG), echocardiography, referral to a cardilologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type):_____Date: _____

Address:_____Phone: _____

Signature of health care professional:_____, MD, DO, NP, or PA

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USA CLIMBING PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name:_____ Date of birth: _____

☐ Medically eligible for competitive climbing without restriction

☐ Medically eligible for competitive climbing without restriction with recommendations for further evaluation or treatment of

_____

_____

_____

☐ Not medically eligible for competitive climbing pending further evaluation

☐ Not medically eligible for competitive climbing

Recommendations: _____

_____

_____

_____

_____

I have examined the athlete named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined in this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of healthcare professional (print or type):_____Date:_____

Address:_____Phone:_____

Signature of health care professional:_____ MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

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