



720 N Webb Rd. Grand Island, Ne 68803

308-384-2500

PHYSICAL CAPACITY PROFILE® MEDICAL HISTORY

COMPANY: \_\_\_\_\_

APPLICANT JOB: \_\_\_\_\_

APPLICANT NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

DOMINANT SIDE: R L

MEDICAL HISTORY: (if you have now or have had any of the following, indicated below, then...) Circle Y (Yes) N (No)

- Y N Smoker \_\_\_\_\_ Y N Neck Pain \_\_\_\_\_
Y N Heart Disease \_\_\_\_\_ Y N Neck Surgery \_\_\_\_\_
Y N Asthma \_\_\_\_\_ Y N Low Back Pain \_\_\_\_\_
Y N Bronchitis \_\_\_\_\_ Y N Prior Back Fracture \_\_\_\_\_
Y N High Blood Pressure \_\_\_\_\_ Y N Prior Episodes of Low Back Pain \_\_\_\_\_
Y N Epilepsy & Seizures \_\_\_\_\_ Y N Low Back Pain at Present, no Leg Pain. \_\_\_\_\_
Y N Diabetes \_\_\_\_\_ Y N Current Intermittent Pain or Spasms, Occasional Into Leg \_\_\_\_\_
Y N Hearing Disorder \_\_\_\_\_ Y N Current Frequent Significant Pain & Leg Pain w/ Muscle Weakness \_\_\_\_\_
Y N Uses Corrective Lenses or Contacts \_\_\_\_\_ Y N Prior Back Surgery w/ No Symptoms. \_\_\_\_\_
Y N Migraine Headaches \_\_\_\_\_ Y N Current Back Pain & Prior Back Surgery \_\_\_\_\_
Y N Emphysema \_\_\_\_\_ Y N Current Back Pain & 2 or More Back Surgeries \_\_\_\_\_
Y N Osteoporosis \_\_\_\_\_ Y N Hip Pain \_\_\_\_\_
Y N Arthritis \_\_\_\_\_ Y N Hip Surgery \_\_\_\_\_
Y N Hernia \_\_\_\_\_ Y N Knee Pain or Problems \_\_\_\_\_
Y N Hernia Surgery \_\_\_\_\_ Y N Prior Knee Injury \_\_\_\_\_
Y N Tendonitis \_\_\_\_\_ Y N Knee Surgery \_\_\_\_\_
Y N Elbow Pain w/ Use \_\_\_\_\_ Y N Heel Pain \_\_\_\_\_
Y N Wrist Pain w/ Use \_\_\_\_\_ Y N Currently/Possibly Pregnant \_\_\_\_\_
Y N Carpal Tunnel Syndrome \_\_\_\_\_ Y N Any Surgeries in the last 4-5 months \_\_\_\_\_
Y N Occasional Numbness w/ Use and Normal Sensation \_\_\_\_\_
Y N Diminished Sensation and Frequent Numbness w/ Use. \_\_\_\_\_
Y N Decreased Sensation and Constant Numbness, Pain w/ Use. \_\_\_\_\_
Y N Prior Carpal Tunnel Surgery \_\_\_\_\_
Y N Shoulder Injury \_\_\_\_\_
Y N Shoulder Pain w/ Use \_\_\_\_\_
Y N Prior Shoulder Surgery \_\_\_\_\_
Y N Fractures or Breaks of Any Bone \_\_\_\_\_

MEDICATIONS TAKING: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

- 1. Weight \_\_\_\_\_ 3. Systolic BP \_\_\_\_\_ 4. Skinfold \_\_\_\_\_
2. Heart Rate \_\_\_\_\_ Diastolic BP \_\_\_\_\_ 5. Spirometry \_\_\_\_\_
Grip Right \_\_\_\_\_ Pinch Right \_\_\_\_\_
6. Grip Left \_\_\_\_\_ 7. Pinch Left \_\_\_\_\_
8. T12 ROM \_\_\_\_\_ 9. Squats \_\_\_\_\_ 10. Situps \_\_\_\_\_ Pile \_\_\_\_\_
Sacral ROM \_\_\_\_\_