



Pre-Season Baseline Assessment



Date:

Athlete:		Date of Birth	
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Subjective

Position:		LHD	RHD
Years active:			
Occupation:			

Past Medical History	
Non-Surgical Injuries:	
Surgical Procedures:	
Diagnostic Imaging:	
Medical History/Medications:	
Alcohol/Smoking History:	
Concussion/Trauma History	

Current Injuries/Concerns:	
Current Symptoms:	
Aggravating Factors:	
Easing Factors:	

Recovery Habits			
<input type="checkbox"/> Ice <input type="checkbox"/> Heat	Prehab:	Medications:	Topical Ointments:
Sleep	Average Hours		
	Wakefulness		
Other			

Objective

Postural Scan	
Static: Scapula	Dynamic Walking
Pelvis	Squat
	OH Reach

Range of Motion			
Neck		Shoulder	
Flexion		Flexion	
Extension		Abduction	
Left Sidebend		External Rotation (0° Abd)	
Right Sidebend		External Rotation (90° Abd)	
Left Rotation		Internal Rotation (90° Abd)	
Right Rotation		Cross Adduction (90° Abd)	
Comments:		Comments:	
Thoracic Spine		Lumbar Spine	
Flexion		Flexion	
Extension		Extension	
Left Rotation		Left Sidebend	
Right Rotation		Right Sidebend	
Comments:		Comments:	
Hip		Ankle	
Flexion		Dorsiflexion	
Extension		Plantarflexion	
External Rotation (90° HF)		Inversion	
Internal Rotation (90° HF)		Eversion	
Comments:		Comments:	

Strength (MMT)				
External Rotation (90* Abd)				
Internal Rotation (90* Abd)				
Latissimus Dorsi				
Upper Trapezius				
Middle Trapezius				
Lower Trapezius				
Power				
Movement	Trial 1 (m)	Trial 2 (m)	Trial 3 (m)	Average
Broad Jump				
SL Broad Jump Left Leg Right Leg				
SL Lateral Broad Jump Left Leg Right Leg				
Palpation:				
Accessory Movements:				
Neural Tension:				
Special Tests:				
Repeated & Sustained Movements:				

Assessment & Plan

Summary of Findings		
Exercise Prescription		
1.		
2.		
3.		
Education / Biomechanics / Lifestyle		
1.		
2.		
3.		
<input type="checkbox"/> Massage Therapy	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Physiotherapy
<input type="checkbox"/> Pelvic Health Consult	<input type="checkbox"/> Running Assessment	<input type="checkbox"/> Vestibular/Concussion
<input type="checkbox"/> Naturopath	<input type="checkbox"/> Psychotherapist	<input type="checkbox"/> Pain Relief / Exercise Products
<input type="checkbox"/> Personal Training	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Other: _____

Notes:

PHYSIOTHERAPIST / CHIROPRACTOR: _____

Signature: