ID Number: _____

Boston Dance Alliance Dance Health Fair Screen

Prepared & submitted by members of the Task Force on Dancer Health, Dance/USA & MGH Institute of Health Professions

Date _____

Name: _____ Date of birth: _____
LAST FIRST

Sex: M_____ F_____ Other:_____ Age: _____

Address: _____

Phone: Home: _____ Cell: _____

E-mail address: _____ Country of origin: _____

Emergency Contact

Name: _____ Relationship: _____
LAST FIRST

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Health Insurance/PRIMARY CARE PHYSICIAN

Health Insurance: _____ ID #:_____

MD Name: _____ Phone:_____

Background information:

Current Company (if any): _____ Position in Company (if any): _____

Number of years of professional dancing:_____Number of hours/week spent in class/rehearsal/performance:_____

Styles of dance currently practiced: _____

Previous work experience as a professional dancer: _____

_____

Please list allergies and medications below:

Yes	No	
❑	❑	Do you have any allergies to medications, foods or environmental agents? Please list specific allergies_____
❑	❑	Do you have an Epi-pen for these allergies?
❑	❑	Are you currently taking any prescription medications? Please list _____
❑	❑	Do you regularly take non-prescription medications, vitamins or supplements? Please list_____

ID Number: _____

General Medical History

(Explain YES answers below. Circle questions you do not know the answers to. If you need assistance with any of the questions below, please ask the health care team only.)

Yes	No		
❑	❑	1.	Has a doctor ever denied or restricted your participation in dance or sports for any reason?
❑	❑	2.	Do you have an ongoing medical condition? ❑ Asthma ❑ Diabetes ❑ Thyroid Disease ❑ Other: Please specify: _____
❑	❑	3.	Do you cough, wheeze, or have difficulty breathing during or after exercise?
❑	❑	4.	Have you ever used an inhaler or taken asthma medicine?
❑	❑	5.	Have you ever passed out or nearly passed out DURING exercise?
❑	❑	6.	Have you ever passed out or nearly passed out AFTER exercise?
❑	❑	7.	Have you ever had discomfort, pain or pressure in your chest during exercise?
❑	❑	8.	Does your heart race or skip beats during exercise?
❑	❑	9.	Has a doctor ever told you that you have: (check all that apply) ❑ High blood pressure ❑ A heart murmur ❑ High cholesterol ❑ A heart infection
❑	❑	10.	Has a doctor ever ordered a test for your heart? (For example: EKG, Echocardiogram)
❑	❑	11.	Has anyone in your family ever died for no apparent reason?
❑	❑	12.	Does anyone in your family have a heart problem?
❑	❑	13.	Has any family member or relative died of heart problems or sudden death before age 50?
❑	❑	14.	Does anyone in your family have Marfans syndrome?
❑	❑	15.	Have you ever spent the night in the hospital?
❑	❑	16.	Have you ever had surgery?
❑	❑	17.	Do you have any rashes, pressure sores or other skin problems?
❑	❑	18.	Have you had infectious mononucleosis (mono) in the past month?
❑	❑	19.	Have you ever had a head injury or concussion?
❑	❑	20.	Have you ever been hit in the head and been confused or lost your memory?
❑	❑	21.	Have you ever had a seizure?
❑	❑	22.	Do you have headaches with exercise?
❑	❑	23.	When exercising in the heat, do you have severe muscle cramps or become ill?
❑	❑	24.	Has a doctor told you that you or someone else in your family has sickle cell trait or sickle cell disease?
❑	❑	25.	Have you had any problems with your eyes or vision?
❑	❑	26.	Do you wear glasses or contacts?
❑	❑	27.	Chicken pox, mumps, measles, rubella Have you been vaccinated for each of the above? ❑ Yes ❑ No ❑ Not sure Are you up to date on your vaccines? ❑Yes ❑ No ❑ Not sure

Give dates and explain details from any items circled or marked "yes" from above

Number Dates and Explanation

_____

_____

_____

Please describe and explain any other medical issues not stated above:

_____

_____

ID Number: _____

Orthopedic History

(Check "yes" or "no." Please indicate what body part was affected in the boxes below.)

Yes No

❑ ❑ 1. Have you ever had an injury, like a sprain, strain or any other injury that caused you to miss more than 2 days of rehearsal or performances? Please indicate where in the box below.

❑ ❑ 2. Have you ever had any broken or fractured bones or dislocated joints?

❑ ❑ 3. Have you ever had surgery for a dance related injury?

❑ ❑ 4 Have you ever been diagnosed with a stress fracture? Where? _____

❑ ❑ 5. Have you ever sprained your ankle? ❑ Right ❑ Left

Neck	Shoulder	Elbow/Wrist/Hand	Rib/Chest	Upper Back	Lower Back
Hip	Thigh	Knee	Calf/shin	Ankle	Foot/Toes

Additional Health Questions

Please complete the appropriate response regarding any concerns you may have with the following:

Yes No

❑ ❑ During the past month have you felt down, depressed or hopeless?

❑ ❑ During the past month have you lost interest or pleasure in doing things?

❑ ❑ Do you feel you suffer from bouts of fatigue or tiredness more than your fellow dancers?

❑ ❑ Do you have trouble falling asleep or getting back to sleep if you wake in the night?

❑ ❑ Do you consider yourself sleep deprived?

❑ ❑ In the past year, have you had a loss of friend(s), or family, or partner/spouse, or pet through death, separation, change in relationship or relocation?

❑ ❑ Do you feel you would benefit from counseling for any of the above?

❑ ❑ Are you interested in nutritional counseling?

❑ ❑ Has anyone recommended you lose or gain weight?

❑ ❑ Do you feel your nutrition is consistently optimal for your dancing?

❑ ❑ Do you take calcium supplements? _____ mg/day

❑ ❑ Do you take Vitamin D? _____ International Units/day

❑ ❑ Do you smoke cigarettes?

If yes: How many years? _____ How many cigarettes per day? _____

How many times in the past year have you had 5 or more drinks in a day? _____

How many times in the past year have you used drugs or medications for non-medical reasons? _____

Other Concerns: _____

_____

ID Number: _____

Date of last physical exam: _____

Date of last dental check up: _____

Questions for women only:

Last gynecological visit:_____

Age of onset of menstruation: _____

Frequency of menstruation (# of times/year)_____

Longest times between cycles _____

Are you currently on any form of birth control? Yes No Please list: _____

ID Number: _____

Physical Assessment

M F Age:_____

Height _____ *(inches)*	Weight_____ *(lbs)*	Blood pressure _____ *(mm/Hg)*

Aerobic Fitness: 3 Minute Step Test

Prep HR____ *(bpm)*	Max HR *(3 minutes)* _____ *(bpm)*	Recovery heart rate *(1 min)* _____ *(bpm)*

Step Test Score: _____

9 Point Beighton Hypermobility Test

	Left		Right	
PROM extension 5th MCP *(>90 degrees)*	(N)eg	(P)os	(N)eg	(P)os
Oppose the thumb to volar aspect of forearm	(N)eg	(P)os	(N)eg	(P)os
Hyperextend elbow *(> 10 degrees)*	(N)eg	(P)os	(N)eg	(P)os
Hyperextend knee *(> 10 degrees)*	(N)eg	(P)os	(N)eg	(P)os
Place hands flat on floor with knees straight	(P)ositive		(N)eg	

Score:_____

Adams Forward Bend Test

Thoracic *(rib hump)*	(S)ymmetric	(L)eft	(R)ight
Lumbar *(Increased mm bulk)*	(S)ymmetric	(L)eft	(R)ight

Passive Range of Motion:

	Left		Right	
Hamstrings tightness *(Hip flexion < 90)*	(N)eg	(P)os	(N)eg	(P)os
Measurement of hamstring with SLR				
FHL tightness *(1st MTP ext <20 degrees with ankle DF)*	(N)eg	(P)os	(N)eg	(P)os
Hip External Rotation, hip extended *(< 45 degrees)*	(N)eg	(P)os	(N)eg	(P)os
Hip Internal Rotation, hip extended *(< 45 degrees)*	(N)eg	(P)os	(N)eg	(P)os

Comments: _____

_____

Strength Tests:

Lower abdominals MMT (Score out of 5)	

	Left		Right	
	MMT	Pain	MMT	Pain
Hip Adductors		□		□
Hip Abductors (Glut med)		□		□
Hip External Rotators		□		□
Hip Extension (Glut max)		□		□
Foot intrinsics *(Lumbricals)*		□		□

Functional Shoulder Assessment:

Repeat 5 times for each position with arms in parallel

	AROM Flexion				AROM Abduction			
	Left		Right		Left		Right	
Elevated scapula	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**
Winging scapula	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**
Abducted scapula	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**
Adducted scapula	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**
Fatiguing	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**	**(N)eg**	**(P)os**

Was any asymmetry in shoulder motion noted? Yes_____ No_____

Balance Unilateral stance: Parallel Passé position:

Cross arms across chest with eyes closed. (Indicate time and circle as appropriate)

Left				Right			
			(sec)				*(sec)*
(N)/A	(T)ouch	(B)reak	(H)op	(N)/A	(T)ouch	(B)reak	(H)op

Single Leg Step Down Test:

	Left	Right
Pelvis	Pass/Fail	Pass/Fail
Knee position	Pass/Fail	Pass/Fail
Trunk position	Pass/Fail	Pass/Fail
Steady stance	Pass/Fail	Pass/Fail
Arm strategy	Pass/Fail	Pass/Fail

Left: ___pass ___ fail (see guidelines for scoring criteria, 0-1 pass, 2-5 fail)
Right: ___pass ___fail

RECOMMENDATIONS:
Areas of concern noted on screening:

_____

_____

_____

_____

_____

Referrals

Primary Care Physician	□
Sports Psych	□
GYN/Endocrine	□
Physical therapy	□
Orthopedic or Sports Med MD	□
Nutritionist	□
Employee Assistance Program	□
Other *(Specify)*_____	□

Exercise Program

Recommended program based on today's findings: Yes No

1.	
2.	
3.	
4.	

Signature: _____ Title: _____

Date completed: _____

Pilot 2006-2007 HS, Revised April 2007 HS, Revised November 2007 HS, Revised March 2011 HS, Revised April 2012 HS, Revised May 2014 H2C/JC/HS, Revised March 2015 EC