CLEVELAND INDIANS

High School Player Profile & Medical Questionnaire

PLAYER INFORMATION									
Last Name		First		M.I.					
Street Address				Apartment/Unit #					
City		State		ZIP					
Phone		Cell		Email					
Position(s)		Bats/Throws		Date of Birth		Height		Weight	

FAMILY INFORMATION					
Father's Name		Father's Occupation		Father's Employer	
Mother's Name		Mother's Occupation		Mother's Employer	
# of Brothers		# of Sisters		Names of Brothers/Sisters	

SCHOOL INFORMATION			
School Name			
School Phone Number			
Coach's Name		Coach's Email	
Coach's Office Phone Number		Coach's Cell Number	
Coach's Home Phone Number			
Grade Point Average		SAT/ACT Scores	
Graduation Date		Guidance Counselor's Name	

ADVISOR INFORMATION	
Do you have an advisor?	
If YES, then Whom?	
If NO, then which advisors or films are you considering at this time?	

COLLEGE INFORMATION
Do you have a college scholarship? If YES, then whom and for how much? If NO, then which schools are considering you?

GENERAL INFORMATION
What interests you about playing professional baseball?
What is it that you do not like about playing professional baseball?

What would you do with your life if you are not able to play professional baseball?
What does it mean to you to be a success? (a) In sports, (b) In life, (c) In school?

In Sports:	
In Life:	
In School:	

Whom do you admire who has played professional baseball?
Why?
Who do you know *personally* who has played professional baseball?
What does a professional contract mean to you?
What do your parents think about the process of your being considered for professional baseball?
What confuses you about the draft process?
What is it about you as a baseball player that we need to know?
What do you know about playing baseball in the minor leagues?
When do you lose focus most easily as a baseball player?
What has happened for you to lose confidence when you play baseball?
What is something that you have been proud of during the past six months?
What is something that you did in the past three months that you regret?
When you are faced with something new that you need to learn, how do you do this?

What are your three (3) strongest qualities, skills? (a) as a baseball player; (b) as a person?			
As a baseball player:			
As a person:			
What are your three (3) biggest limitations? (a) as a baseball player; (b) as a person?			
As a baseball player:			
As a person:			

What does the game of baseball mean to you?
What does failure mean to you?
What can we count on from you if we sign you?
What else would you like to tell us?

MEDICAL INFORMATION

Have you had any surgeries or operations?
If YES, please complete the questions below:

Date:	
Procedure Performed:	
Physician:	
Hospital/City:	

Have you ever had any orthopedic baseball or non-baseball related injuries or symptoms? (i.e. back pain, neck pain, dislocations, separations, fractures, sprains and muscle strains)
If YES, please explain:
Have you ever had an injury to your throwing arm, elbow or shoulder?
If YES, please explain:

Have you ever had any treatments (injections, physical or massage therapy, chiropractic care, medications, bracing, special taping) for any orthopedic or non-baseball related injuries or symptoms?
If YES, please explain:
Have you ever had an MRI, CT Scan, Bone Scan or Arthrogram?
If YES, please complete the questions below:

Date:	
Test:	
Reason:	

Are you presently free of all symptoms, injury, illness or discomfort?
If NO, please explain:
Do you have any general medical problems (asthma, heart defect, high blood pressure, illness or surgery)?
If YES, please explain:
Are you currently taking or in the past four years have you taken any medications or pills (prescription and/or over the counter)?
If YES, please list:
Have you ever been diagnosed with a learning disability, attention deficit/hyperactivity disorder, dyslexia, depression or another disorder?
If YES, please list diagnosis and date of diagnosis:

Date:		Diagnosis:	

Do you use any of the following tobacco products?

Cigarettes:		Cigars:		Smokeless tobacco/dip:	

Do you drink alcohol? (Never, Occasionally, Moderately, Frequent)
Do you have any allergies? If YES, please explain:

In the past four years have you or any family members suffered from or been treated for any of the following? (YES or NO)					
Heart Disease		Diabetes		High Blood Pressure	
Mental Illness		Stroke		Cancer	
In the past four (4) years has anyone in your family died of a sudden death before the age of 50?					
If YES, please explain:					
Have you ever had any vision problems? If YES, please explain:					
Do you have problems seeing at night? If YES, please explain:					
Do you wear glasses?		Do you wear contacts?			
Do you wear glasses or contacts when you compete in athletics?					
When and where was your last eye examination?					
Date:		Location/Physician:			
Please give an approximate date and the name of physician you gave your last physical examination:					
Date:		Location/Physician:			

DISCLAIMER AND SIGNATURE			
By typing my full name below I hereby state that all of the above questions have been answered completely and truthfully to the best of my knowledge.			
Signature		**Date**	