NEUROSPORT ELITE

Sports Performance Pre-Screening Questionnaire

- Name:_____
- Address:_____
- City_____State_____ZIP_____
- Phone: _____ Email: _____
- D.O.B:_____ Age:_____ Height:_____ Weight:_____
- T-shirt Size: _____ Sport(s):_____
- Position(s): _____
- School / Team(s): _____
- Training Experience (how long, where, type of programs, etc.)

  _____

- What are your performance based strengths (speed, strength, power, agility, balance, conditioning, etc.)?:

  _____

- What are your performance based weaknesses (speed, strength, power, agility, balance, conditioning, etc.)?:

  _____

- What sport specific aspects of your game would you like to see improve after treatment or this training program?:

  _____

- What are your athletic career goals (Varsity, College, Pro, etc.)?:

  _____

- Have you had any head injuries (Concussions, Sub concussive blows) If so, when?

  _____

- Do you have any physical limitations or concerns that we should be aware of (major injuries, nagging injuries, previous surgeries, asthma, heart conditions, etc.)?

  _____

- Do you or have you in the past experienced chest pain, dizziness, fainting, during or after exertion?_____ If yes, please describe: _____

  Current vitamins and / or herbs, including dosage if known.

  If there are NO current vitamins / herbs, check here: ❑

  1) _____ 5) _____

  2) _____ 6) _____

  3) _____ 7) _____

  4) _____ 8) _____

- Current medications, including dosage if known.

  If there are NO current medications, check here: ❑

  1) _____ 5) _____

  2) _____ 6) _____

  3) _____ 7) _____

  4) _____ 8) _____

- List any known allergies.

  If NO allergies are known, check here: ❑

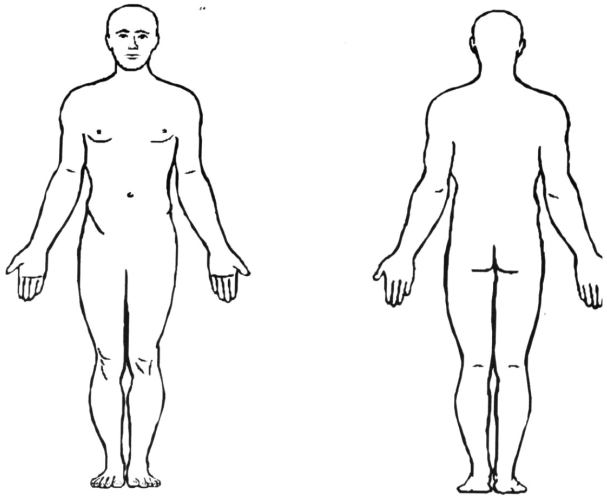
  1) _____ 3) _____

  2) _____ 4) _____

- Do you have any major physical complaints? Please describe:_____

  _____

- Please place a circle around the area of complaint:
- Please place an X over the area you want to strengthen:



- How long have you had this condition?

  _____

- Have you had this or similar conditions in the past?

  _____

- Do any positions make it feel worse?

  _____

- Do any positions make it feel better?

  _____

- Is this condition: ❑ Improved ❑ Unchanged ❑ Getting Worse

- Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine

  Other _____

- What do you think caused this condition?

  _____

- List three other health concerns:

  1) _____ 3) _____

  2) _____

- List surgical operations and years:

  _____

  _____

- Date of last physical:_____ Primary Care Physician: _____
- Primary Care Physician Address / Phone:

  City_____ State:_____ Phone: _____
- Emergency Contact _____ Relationship to you:_____

  Emergency Contact Phone Number:

  _____

  Participant's Signature

  _____

  Date _____

- Signature of Parent or Legal Guardian (if participant is under 18 years of age):

  _____ Date _____