Sport Performance Evaluation

Name: ____ Birth Date: ______________ Today's Date:______________

Grade: __________ School: ______________________________ Sport: ____________________________ Gender M F

Address: ____ Home Phone : ________________

Parent's Name: ____ Daytime Phone: ______________

Height: ____________ Weight: _______________ E-mail address: ____

Athlete/Player History

	Yes	No		Yes	No
Any significant past injuries			Seizures, Head Injury or Concussion		
Allergies, Asthma or Wheezing			Neck or Upper Back Pain		
Contact Lenses or Glasses			Mid Back Pain		
Currently on Medication (s)			Lower Back Pain		
Chronic Illness			Shoulder, Elbow, Wrist or Hand Pain		
Hospitalization or Surgeries			Hip, Knee, Ankle or Foot Pain		

Comments:

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Rate Your Pain: (0-10, 0=No Pain, 10=Worst Pain) 1 2 3 4 5 6 7 8 9 10

Have you had previous Chiropractic Care? Y N When? ____

Parent/Guardian

I, ____________________________ being the parent or legal guardian of __________________________

hereby grant permission for my child to receive chiropractic evaluation, examination and treatment in-cluding pre-game chiropractic adjustments and sideline care by the team chiropractor.

Signature: ____ Date: ____________________________

Name Printed: ____ Relationship to Player:______________

Address: ____ Phone: _________________________

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