Allergies, Asthma or Wheezing Contact Lenses or Glasses Mid Back Pain Currently on Medication (s) Chronic Illness Neck or Upper Back Pain Lower Back Pain Shoulder, Elbow, Wrist or Hand Pain		Spo	rt Perfo	rma	ance Evaluation	า			
Address:	Name:				Birth Date: Today's Date:				
Parent's Name:	Grade:				Sport:	(Gender	М	F
Athlete/Player History Yes No Yes No Yes No	Address:					Home Phone :			
Athlete/Player History Yes No Yes Ye	Parent's Name	2:				Daytime Phone:			
Any significant past injuries Allergies, Asthma or Wheezing Neck or Upper Back Pain Contact Lenses or Glasses Mid Back Pain Chronic Illness Shoulder, Elbow, Wrist or Hand Pain Hospitalization or Surgeries Comments: 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,	Height:	Weight:	E-mail address:						
Any significant past injuries Allergies, Asthma or Wheezing Contact Lenses or Glasses Currently on Medication (s) Chronic Illness Hospitalization or Surgeries Comments: Rate Your Pain: (0-10, 0=No Pain, 10=Worst Pain) I,	Athlete	e/Player Histor	ry						
Allergies, Asthma or Wheezing			Yes	No				Yes	No
Contact Lenses or Glasses Currently on Medication (s) Chronic Illness Shoulder, Elbow, Wrist or Hand Pain Hospitalization or Surgeries Hip, Knee, Ankle or Foot Pain Comments: 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,	Any significant past injuries				Seizures, Head Injury or Concussion				
Currently on Medication (s) Chronic Illness Shoulder, Elbow, Wrist or Hand Pain Hospitalization or Surgeries Hip, Knee, Ankle or Foot Pain Comments: 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,	Allergies, Asthma or Wheezing				Neck or Upper Back Pai	pper Back Pain			
Chronic Illness Shoulder, Elbow, Wrist or Hand Pain Hip, Knee, Ankle or Foot Pain Comments:	Contact Lenses or Glasses				Mid Back Pain	I			
Hospitalization or Surgeries Hip, Knee, Ankle or Foot Pain Comments: 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,	Currently on Medication (s)				Lower Back Pain	ain			
Comments: 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 including pre-game chiropractic adjustments and sideline care by the team chiropractor. Signature: Date: Date: Name Printed: Relationship to Player:	Chronic Illness				Shoulder, Elbow, Wrist	, Wrist or Hand Pain			
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,	Hospitalization or Surgeries				Hip, Knee, Ankle or Foo	p, Knee, Ankle or Foot Pain			
I,	Rate Your Pa	ain: (0-10, 0=No Pain, 10							
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Name Printed: Relationship to Player:							reatme	nt in	=
Address: Phone:				Relationship to Player:					
	Address:				Phone: _				