PRE-FIGHT NEUROLOGICAL EVALUATION FORM

NAME: _____ DATE: _____

AGE: _____ HANDED: RIGHT _____ LEFT _____

YEARS BOXING: _____ FIGHT RECORD: _____ LAST FIGHT: _____

OCCUPATION:
_____

COMMENTS:
_____

_____

_____

NEUROLOGICAL EXAMINATION:

VITAL SIGNS: BP: _____/_____ PULSE: _____ HEIGHT: _____ WEIGHT: _____

MENTAL STAUTS EXAM: NORMAL ABNORMAL

CRANIAL NERVES: NORMAL ABNORMAL

MOTOR EXAM: NORMAL ABNORMAL

DTR EXAM: NORMAL ABNORMAL

CEREBELLAR: NORMAL ABNORMAL

SENSORY EXAM: NORMAL ABNORMAL

GAIT EXAM: NORMAL ABNORMAL

COMMENTS:

_____

_____

_____

THE FIGHTER : IS IS NOT MEDICALLY CLEARED TO PARTICIPATE

Physicians Name:
_____

Physician Signature:
_____

Address: _____ City:
_____

State: _____ Country: _____ Zip:
_____

Phone: _____ Fax:
_____