# 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:**
**_____**