



PRE-FIGHT NEUROLOGICAL EVALUATION FORM

(Form must be completed by a neurologist or neurosurgeon)

NAME: _____ DATE: _____

AGE: _____ HANDED: RIGHT _____ LEFT _____

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

OCCUPATION: _____

COMMENTS: _____

NEUROLOGICAL EXAMINATION:

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

MENTAL STATUS 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: _____