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: ______________________

Forms Courtesy of:
Dr. Michael Schwartz
Co-Chairman – Medical Advisory Committee