



**Pre-screening questionnaire:**

Name (First and Last): \_\_\_\_\_ DOB: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Emergency Contact (1): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Emergency Contact (2): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Allergies/Medications? \_\_\_\_\_  
\_\_\_\_\_

Medical Conditions (Asthma? Heart? Diabetes?) \_\_\_\_\_  
\_\_\_\_\_

Any prior orthopedic injuries or surgeries? \_\_\_\_\_  
\_\_\_\_\_

*\*\*If you have experienced any lower extremity injury or surgery within the past year, please provide a letter by the first day from MD or surgeon for clearance of full participation in physical activity and sports.*

Sport(s) participating in? \_\_\_\_\_