DEVELOPMENTAL FOOTBALL INTERNATIONAL

DFI INCOMING FOOTBALL ACTIVITY QUESTIONNAIRE

Full Name: _____ Date: _____

S.S.# _____ DOB: _____

Family Doctor: _____

High School: _____

DFI Coach/Contact: _____

Home Address: _____

City: ____ _____

State:_____Zip:_____

Phone: _____

Father's Name: _____

Mother's Name: _____

Address (F): _____

Address (M): _____

Home Phone: (F) _____

Home Phone: (M) _____

Employer: _____

Employer: _____

Work Phone: (F) _____

Work Phone: (M) _____

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Please complete the following information for any injuries that you have incurred over THE LAST FOUR YEARS ONLY. Please include any injuries that are not healed at this time. Please list any surgeries or rehabilitation within the comments section.

1. Concussion or Head Injuries: No _____Yes _____Left _____Right _____ Date _____ Comments:

2. Neck Injuries: No _____ Yes _____Left _____Right _____ Date _____ Comments:
   Have you ever seen a Chiropractor? No _____ Yes _____

3. Shoulder Injuries: No _____ Yes _____Left _____Right _____ Date _____ Comments:

4. AC Sprains? No _____ Yes _____Left _____Right _____ Date _____ Comments:

5. Elbow Injuries: No _____ Yes _____Left _____Right _____ Date _____ Comments:

6. Wrist Injuries: No _____ Yes _____Left _____Right _____ Date _____ Comments:

7. Hand or Finger Injuries: No _____ Yes _____Left _____Right _____ Date _____ Comments:

8. Back Injuries: No _____ Yes _____Left _____Right _____ Date _____ Comments:

9. Are you able to perform all of your weight room exercises? No _____ Yes _____

10. Have you ever seen a Chiropractor for your back? No _____ Yes _____

11. Hip or Thigh Injuries (i.e. hamstrings, groin, quadriceps, hip flexors, etc…)
    No _____ Yes _____Left _____Right _____ Date _____
    Comments:

12. Knee Injuries: No _____ Yes _____Left _____Right _____ Date _____ Comments:

13. Ankle Injuries: No _____ Yes _____Left _____Right _____ Date _____ Comments:

14. Foot Injuries: No _____ Yes _____Left _____Right _____ Date _____ Comments:

Please indicate if any of the following pertain to you. If need be, explain in writing on the back of this questionnaire.

15. Allergies: (If yes, to what?)
16. Cardiac Abnormalities: Have you ever received diagnostic testing?
17. Sickle Cell Anemia/Trait: Have you ever been tested?
18. Asthma: (If yes, how is it treated?)
19. High or Low Blood Pressure:
20. Epilepsy:
21. Migraines:
22. Chronic Muscle Strains:
23. Diabetes:
24. Do you wear glasses or contacts? Are they just for sports?
25. Do you take any medicines or supplements regularly?
26. Do you require any special taping or bracing?
27. Do you have any heat-related injuries?
28. Loss of consciousness, numbing or tingling?
29. Have you ever had X-rays?
30. Have you ever had a MRI or Bone Scan?
31. Have you ever seen a Physical Therapist?
32. Have you ever seen a Chiropractor?