



***Vancliffen Audition -- Competition --Workshops  
Dance Health Questionnaire***

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No \_\_\_\_\_

Name: \_\_\_\_\_ Last Name : \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ P C: \_\_\_\_\_

Email: \_\_\_\_\_ Tel. \_\_\_\_\_

Doctor's Name : \_\_\_\_\_ Tel. \_\_\_\_\_

Therapist's Name: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Email : \_\_\_\_\_ Tel. \_\_\_\_\_

Date last visited :  
\_\_\_\_\_

Reasons for : \_\_\_\_\_

In the last 6 months have you had any accidents  
or need for physical therapy      YES      NO      Date: \_\_\_\_\_

Type of Accident: \_\_\_\_\_

Duration of therapy : \_\_\_\_\_

In the past have you had any physical problems that  
have an influence on your dance activity      YES      NO      Date  
: \_\_\_\_\_

Type : \_\_\_\_\_

Have you returned to complete physical activity: Totally      Partially      Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Participants Signature, parents or legal guardian ( if under the age of 18 )