



**GURNEE
PODIATRY &
SPORTS MEDICINE
ASSOC.**

Treatment • Prevention • Rehabilitation

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Dancer Questionnaire

Name: _____ Date of Birth: _____

Total years dancing: _____ Started at age: _____

Do you have your period? _____ Do you smoke? _____

Do you eat Breakfast? _____ Lunch? _____ Dinner? _____

Dance Styles: Ballet Modern Jazz Lyrical Tap Hip Hop Ballroom Ethnic Irish
Other: _____

What age did you go on Pointe? _____

How many classes/hours do you take each week? _____ Ballet _____ Jazz _____ Modern _____

Tap _____ Pointe _____ Irish _____ Hip Hop/Ballroom/Ethnic: _____

Do you teach classes? Yes No Type/How many per week? _____

Dance (Pointe') Shoes name: _____ How often do you change pointe shoes? _____

Have you been professionally fit? _____ Where? _____

Do you wear orthotic devices? Yes No Do you warm up? Yes No

If so, how? Static Stretching Massage Barre Plyometrics Dynamic Stretching Yoga Poses

Other: _____

Do you strength train? Stretch Bands Free Weights Weight Machines

Do you participate in any Yoga or Pilates? Yes No How often? _____

Do you do cardio activities other than dancing? Yes No If so which? _____

What injuries have you experienced with dancing? _____

Did it keep you from dancing? Yes No For how long? _____

Have you had any surgery related to dance/athletics? _____

Where do you take classes/address? _____

Are you affiliated with any dance Company? _____

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