DANCER ACTIVITY QUESTIONNAIRE

NAME:

DATE STOPPED TRAINING AT STUDIO:

Do you have any respiratory illness/other concerns? YES/ NO

Please list all other concerns

Are you suffering from any injuries? YES/ NO

Please list previous injuries

Any new injuries since training stopped?

Training Two Weeks Ago (Insert Date:)

	Hours	Intensity (0-10)	List top 3 activities
Week 1			
Week 2			

On a scale of 1-10, rate what you feel to be your current fitness level (compared to your last day in the studio).

1 2 3 4 5 6 7 8 9 10

List any concerns you may have about your return to the studio...

Provide any suggestions of how you feel your teachers can support you returning to full training...

PERFORMANCE MEDICINE

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References Gymnastics Australia, June 2020 Return to Training & Performance Principles ; USA Gymnastics, Physical and Mental Health Guidance for a Safe Reintegration of Gymnastics after COVID-19 Restrictions from Training