Teen Volleyball Performance Training Intake Form

Parent or guardian and athlete: complete this form before the first assessment. Your answers help us plan training around the athlete's goals, schedule, and current health.

Athlete and family information

Athlete full name _____

Date of birth / age _____

Parent or guardian name _____

Relationship to athlete _____

Parent or guardian phone _____

Email _____

Emergency contact name _____

Emergency contact phone _____

School / club team _____

Grade _____

Preferred contact method ☐Text ☐Phone ☐Email

Volleyball background and goals

Primary position ☐Setter ☐Outside ☐Opposite ☐Middle ☐Libero / DS ☐Other

Years playing volleyball _____

Current level ☐School ☐Club ☐Recreational ☐Other

What does the athlete most want to improve? Include specific goals such as vertical jump, approach jump, first step, lateral movement, landing, strength, or confidence.

_____

What does the parent or guardian most want training to accomplish?

_____

Top priorities ☐Jump height ☐Power ☐Speed ☐Agility ☐Strength

Other priorities ☐Landing control ☐Balance ☐Mobility ☐Injury resilience ☐Other

Training load and availability

Volleyball practices per week _____

Games / tournaments per month _____

Other sports or physical activities _____

Current strength, conditioning, or jump training and typical weekly schedule

_____

Preferred training days and times _____

Health and movement history

A parent or guardian should complete this section with the athlete. Describe current issues even if they seem minor. Training is adjusted around symptoms and any clinician guidance.

Currently experiencing pain or symptoms during activity? ☐No ☐Yes

If yes, where, when, and what movements make it better or worse?

_____

History of injury, surgery, concussion, or recurring pain? ☐No ☐Yes

If yes, describe the issue, date, treatment, and any ongoing limitation.

_____

Current or recent care from a doctor, physical therapist, or athletic trainer? ☐No ☐Yes

If yes, list the provider's restrictions, recommendations, and any return to activity guidance.

_____

Areas needing attention ☐Back ☐Knee ☐Ankle ☐Hip ☐Shoulder ☐Other

Any condition that may affect exercise or require a response plan? ☐No ☐Yes

If yes, explain relevant details and what the coach should do if symptoms occur. Include allergies, asthma, fainting, or other concerns if applicable.

_____

Medications that may affect training, if relevant _____

Cleared for unrestricted sports participation? ☐Yes ☐No ☐Unsure

Recovery and training preferences

Typical sleep on school nights ☐Under 7 hours ☐7 to 8 hours ☐8 to 9 hours ☐Over 9 hours

What training activities does the athlete enjoy or find difficult?

_____

Anything else the coach should know about motivation, communication, or schedule?

_____

Parent or guardian acknowledgment

I confirm that I am the athlete's parent or legal guardian and have provided accurate information to the best of my knowledge. I will notify Next Mission Fitness of changes in health, symptoms, restrictions, or sports clearance. I understand that training involves physical effort and that the athlete should stop and tell the coach if pain, dizziness, or unusual symptoms occur. I authorize my child to participate in the assessment and training activities selected by Next Mission Fitness, subject to any restrictions disclosed above.

This acknowledgment supports program planning. It does not replace medical evaluation or a separate service agreement. If the athlete has a current restriction or is not cleared for sport, provide the applicable clinician guidance before training begins.

Parent or guardian printed name _____

Parent or guardian signature _____

Date _____

Athlete signature _____

Date _____

Optional media permission

Choose one. This permission is optional and does not affect eligibility for training.

Photos or video for coaching review shared privately with my family ☐Yes ☐No

Photos or video for Next Mission Fitness marketing or social media ☐Yes ☐No