revolution
chiropractic wellness center

ZING PERFORMANCE

# Cerebellum Reset Assessment

**Name:** _____

**Address:** _____

_____

**Email:** _____

**Phone Number:** _____

**Birthdate:** _____

**School & Grade Level:** _____

**Reason for Visit:** _____

_____

_____

_____

_____

**Areas of Concern (check all that apply):**

- ☐ Focus & Concentration
- ☐ Learning Struggles
- ☐ Difficulty Paying Attention
- ☐ Difficulty Reading
- ☐ Behavioral Concerns
- ☐ Other:

**My Child Has Received a Diagnosis of (check all that apply):**

- ☐ Dyslexia
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Other:

**Signature:** _____ **Date:** _____