

Medical information

Personal details

NAME SURNAME D.O.B

D	D	M	M	Y	Y	Y	Y
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Medical history – do you have any of the following?

THYROID PROBLEMS	Y	N	EPILEPSY	Y	N	RECENT SURGERY	Y	N
	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
HEART CONDITIONS	<input type="radio"/>	<input type="radio"/>	ARTHRITIS	<input type="radio"/>	<input type="radio"/>	CANCER	<input type="radio"/>	<input type="radio"/>
RESPIRATORY CONDITIONS	<input type="radio"/>	<input type="radio"/>	DIABETES	<input type="radio"/>	<input type="radio"/>	ARE YOU PREGNANT?	<input type="radio"/>	<input type="radio"/>

If yes, please provide details

Previous musculoskeletal injury history, including fractures

Any other general health issues or concerns?
e.g: IBS / skin conditions

Medication

ARE YOU CURRENTLY TAKING ANY MEDICATION?
INCLUDING ANTICOAGULANTS (BLOOD THINNING MEDICATION)

Y	N
<input type="radio"/>	<input type="radio"/>

 If yes, please provide details

ARE YOU CURRENTLY TAKING OR EVER BEEN PRESCRIBED STEROIDS?

<input type="radio"/>	<input type="radio"/>
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Lifestyle

HOW MANY HOURS DO YOU SPEND SITTING EACH DAY?

HOW MANY HOURS SLEEP DO YOU AVERAGE PER NIGHT?

HOW WOULD YOU DESCRIBE YOUR STRESS LEVELS? HIGH MEDIUM LOW

WHAT ARE YOUR STRATEGIES TO MANAGE STRESS?

DO YOU HAVE ANY DIETARY OR NUTRITIONAL ISSUES?

DO YOU SMOKE?

Y	N
<input type="radio"/>	<input type="radio"/>

DO YOU PARTICIPATE IN A STRUCTURED EXERCISE PROGRAMME?

<input type="radio"/>	<input type="radio"/>
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If yes, please provide details