Name…… **DOB……..**

Health Check List

Please complete this health-screening questionnaire, which will help us to assess your needs.

Do you suffer from any of the following conditions?

	Circle as appropriate	**(If yes please provide full details below)**
Diabetes	Yes	No
- Type I or type II		
Epilepsy	Yes	No
Headaches or migraine	Yes	No
Heart conditions	Yes	No
- E.g. angina, heart attack, heart murmur		
Lung conditions	Yes	No
- E.g. asthma, bronchiectasis, COPD, tuberculosis		
Haemophilia	Yes	No
Cancer	Yes	No
HIV	Yes	No
Bone Conditions	Yes	No
- E.g. osteoporosis		
High blood pressure	Yes	No
Low blood pressure	Yes	No
Back pain	Yes	No
Muscle, nerve or joint problems	Yes	No
- E.g. arthritis, repetitive strain injury,		
- Recurrent injuries, carpel tunnel syndrome		
Stroke or head injury	Yes	No
Genetic disorders	Yes	No
- E.g. cystic fibrosis, muscular dystrophy		
Neurological conditions	Yes	No
- E.g. multiple sclerosis, guillain barre syndrome		

Name…… **DOB……..**

Circle as appropriate (If yes please provide full details)

Mental health problems Yes No

- E.g. depression, anxiety

Dizziness, labarynthitis or vertigo Yes No

Are you currently pregnant / think you might be pregnant?

Yes No N/A

Have you fractured any bones in the past? Yes No

Do you have any metal implants Yes No

Do you have a pacemaker Yes No

Do you suffer from any allergies Yes No

Please list any operations you have had with dates.

Please list all your current medications (including blood thinners and steroids).

Please use this space to list any other conditions, not already mentioned above.

All information given above is treated with the strictest level of confidentiality and will not be divulged to any third party, except a health professional if we transfer your care to them, without prior consent. This information will be used to help us to assess your medical needs.

Signed: _____ Date: _____