HEALTH QUESTIONNAIRE

Please complete both sides of this form, fold where indicated and return with your payment method to us prior to your first class.
All information supplied is completely confidential and will be bound under the Data Protection act 1998.

Name:

Email:

Address:

Telephone:

Date of Birth:

MEDICAL HISTORY:

1. Do you suffer from any heart troubles? If "yes", please give details here:

2. Do you have high or low blood pressure? If "yes", please give details here:

3. Do you often feel faint or have spells of servere dizziness? If "yes", please give details here:

4. Do you suffer with any aches/pains in your bones/joints? If "yes", please give details here:

5. Do you suffer with from back pain? If "yes", please give details here:

6. Do you take any form of medication? If "yes", please give details here:

7. Have you had a recent injuries or operations? If "yes", please give details here:

8. Are you pregnant or have recently had a baby? If "yes", please give details here:

9. Please let us know of any conditions that you have been diagnosed with or been treated for by a physician:
(For example: Asthma, Back Pain, Cancer, Diabetes, Bronchitis, Obesity, Arthritis, Stroke, Epilepsy, etc.)

By submitting this form, you willingly participate in the practical exercises at your own risk. You confirm that have no physical restrictions, disabilities or any predisposition to sickness or injury that may be aggravated or adversely affected as a result of your participation. You take full responsibility for any injury, loss or damage to your person or property that may arise directly or indirectly from your participation in the exercises. I will not seek to penalise, prosecute or claim compensation from the company for any injury, loss or damage.

Signed:

Date: