



This questionnaire is for your safety and our information. The information is strictly confidential.

(Mr/Mrs/Miss/Ms)	Surname	First Name
D.O.B	M/F	Height
Weight		
Address		
Contact Numbers: Day	Eve	Mobile
Email:		
In case of an emergency contact:		
Name	Contact Number	Relationship

Client Lifestyle Details	
Occupation	Full/Part time
Hobbies/interests/activities	
Physically related work activities	
GP Details	
Name	Contact Number
Surgery Address	

Medical Check List

Have you had any of the following? If yes, please tick

Heart Conditions	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	HRT	<input type="checkbox"/>
Bladder problems	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	Long Term steroids	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>
Car accident	<input type="checkbox"/>	Gynaecological Problems	<input type="checkbox"/>	Circulation problems	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Anti Coagulant Therapy	<input type="checkbox"/>	Operations	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Other (see details)	<input type="checkbox"/>
Details:					

I understand that I am responsible for the cost of my treatment. Should I fail to attend a treatment without giving 24 hours prior notice then I am liable for a cancellation fee.

Signature: _____ Date: _____