FITNESS & TRAINING

Medical History Questionnaire

Personal details

First name: Last name:

Address:

Tel: h w mobile

Gender: Date of birth:

Emergency contact

First name: Last name:

Address:

Tel: h w mobile

Relationship:

Medical details

Blood group: Do you object to transfusions?

Have you received a medical clearance from your doctor?

Do you have any allergies?

If yes, please list:

Please list any medical conditions that you have (for example, asthma, diabetes, epilepsy):

Please list any regular medications you require (including dosage):

On average, how many hours of sleep do you get each night?

On average, what is your energy level like each day?

Sports injury details

Please list any current or recurring injuries:

Do you suffer from recurring pain in any joint when playing sport? y / n
(please circle) If yes, please provide details:

Do you wear protective equipment? (for example, mouthguard, head gear) y / n
(please circle)
If yes, please provide details:

Do you require specific taping/padding for a previous injury? y / n
(please circle) If yes, please provide details:

Have you ever had a head, neck or spinal injury? y / no
(please circle)
If yes, please provide details:

To the best of my knowledge, all information contained on this form is correct:

Client's sign here:

Signature:

Date:

If conserved or under 18 Guardian please sign here:

Signature:

Date: