Name: **Date:**

Address:

NHS Number: **Telephone Number:**

DOB: **Mobile Telephone Number:**

GP Name:

To help the Therapist with your assessment, please complete this health questionnaire by answering the following questions:-

	Yes	No	If 'yes' please give additional information
Do you have a pacemaker	☐	☐	
Do you have osteoporosis (thinning bone)	☐	☐	
Have you ever been diagnosed with TB	☐	☐	
Have you ever been diagnosed with rheumatoid arthritis / connective tissue disorder	☐	☐	
Have you ever been diagnosed with angina or any heart problems	☐	☐	
Have you ever been diagnosed with any respiratory problems including asthma	☐	☐	
Have you ever been diagnosed with diabetes	☐	☐	
Have you ever been diagnosed with epilepsy or had a fit	☐	☐	
Have you ever been diagnosed with blood pressure problems	☐	☐	
Have you had any operations	☐	☐	
Have you had any broken bones	☐	☐	
Are you pregnant	☐	☐	
Have you taken, or are you currently taking steroids	☐	☐	

PTO:

Name: **UN:** **DOB:**

	Yes	No	If 'yes' please give additional information
Are you taking blood thinning medication Warfarin / Heparin / Clopidogrel / Aspirin	☐	☐	
Have you had, or been treated for cancer	☐	☐	
Have you had a DVT (blood clot)	☐	☐	
Have you suddenly lost weight without trying	☐	☐	
Have you been generally unwell	☐	☐	
Have you ever been diagnosed with any other illness or condition	☐	☐	
Do you smoke	☐	☐	
Do you drink alcohol	☐	☐	
If yes, how many units per week	☐		
Are you taking any prescribed or none prescribed medication	☐	☐	

Please have a list of your medication available

Therapist additional comments

Declaration

I consent to be assessed and treated by a qualified physiotherapist or occupational therapist or by a student or support worker, working under direction from a qualified therapist

Patient signature:.. **Date:**.........................

Therapist signature:... **Date:**.........................

Therapist Name:............................... ....