Health questionnaire

Name:

Email:

Telephone:

Address:

Date of Birth:

Emergency contact details:

1. Do you have, any physical conditions or injuries that your instructor should know about?

2. Do you have a tendency to lose consciousness or fall over as a result of dizziness?

3. Are you on any medication?

4. Do you have issues with your bones or joints ?

5. Do you have a cardiac conditions?

6. Are you pregnant or have has a baby in the last 12 months?

7. Do you have uncontrolled high or low pressure?

8. Do you have any eye, ear or throat issues?

9. Do you have varicose veins?

10. Have you had any operations?

11. Do you have any type of hernias or prolapses?

12. Do you suffer any form of menstrual disorder?

13. Do you have any allergies?

If you answered yes to any of the above please give further details below.

Sign
Date