PLUS HEALTH COMPANY REGISTRATION & HEALTH SCREENING

Revised Jan2020

Title:	Full Name:	DOB:
Postal Address:		Postcode:
Registered GP Practice:		Occupation:
Mobile Tel:		Email:
Name of Emergency Contact (and relationship to you):		Contact mobile number of Emergency Contact:

Please answer the following and tick/detail as appropriate:	Yes	No
Do you suffer from any respiratory conditions e.g. Asthma, COPD? If yes, please list the condition, medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
Do you have epilepsy? If yes, please list any medication(s) taken the date of your last seizure and confirm whether the condition is well-managed/stable or unstable/requiring regular review. Please write details below:		
Are you diabetic? If yes, please list the type (type 1 or type 2), any medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
Do you have heart problems? If yes, please list the name of the condition, medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
Do you suffer from or have you previous had any circulatory disorders e.g. varicose veins, thrombosis, atherosclerosis, high blood pressure, low blood pressure, haemophilia? If yes, please list the name of the condition, medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		

Have you had or do you currently have any major illnesses such as cancer? If yes, please list the area(s) affected, year diagnosed, the form (if known), how it was/is being treated and whether you are still under review. Please write details below:		
Do you have a mental health issue such as anxiety or depression? If yes, please list the condition, when you were diagnosed (year) and any treatment to date (including medication, talking therapy). Please write details below:		
Do you a thyroid problem? If yes, please list the condition (hypo/hyperthyroidism), medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
Do you regularly feel lethargic, fatigued or excessively tired? If yes, please state whether this has been investigated (and when), if a cause has been established and how it is being managed (ie vitamin supplementation). Please write details below:		
Have you been investigated for or diagnosed with a vitamin D deficiency? If yes, please list when you were investigated (month/year), if you were found to be deficient and what medication (and dose) you are taking to manage this condition:		
Have you been diagnosed with or investigated for Osteoporosis or Osteopenia (brittle bones)? If yes, please list when you were investigated (year), if you were diagnosed as osteo*porotic* or osteo*penic,* whether you have had any related fractures and what medication you are taking to manage this condition:		
Have you ever had any fractures/broken bones? If yes, please list the location(s), whether surgery was required and if instrumentation was used (ie metalwork). Please write details below:		
Do you suffer from Osteoarthritis (OA)? If yes, please list the location(s), medication(s) taken and the approximate date of any xrays/scans. Please write details below:		

Have you been investigated or diagnosed with any rheumatology conditions such as rheumatoid arthritis (RA) or ankylosing spondylitis (AS)? If yes, please list the condition, medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
Have you been diagnosed with or investigated for a neurological condition such as MS, parkinsons or stroke? If yes, please list the condition, medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
Do you regularly fall, trip or lose balance? If yes, please give some details (including the date, location and any injuries sustained) about your last incident below:		
Do you have a history of spinal problems e.g. neck/upper/lower back pain, whiplash, scoliosis? If yes, please list the area(s) affected, whether you have had any x-rays or scans, any treatment to date (ie previous physio/injections etc) and whether it is a current issue. Please write details below:		
Do you suffer from pins & needles sensations or numbness? If yes, please list the area(s) affected, whether the cause has been established and if you are taking any medication to help manage this. Please write details below:		
Have you had any major operations or are you awaiting any surgical procedures? (ie joint replacement surgery, hysterectomy, arthroscopy) If yes, please list the surgery and the month/year as well the reason for it. Please write details below:		
Do you have any allergies ie. Latex/plasters? If yes, please list your allergies and any medication(s) taken to manage these. Please write details below:		
Do you suffer from any skin disorders e.g. eczema/psoriasis? If yes, please list your allergies and any medication(s) taken to manage these. Please write details below:		

Do you have any undiagnosed lumps or bumps? If yes, please list where it is, how long you have had it and reason(s) you haven't had it checked out. Please detail below:		
Women only: If you have had biological children, please state the age range of your child/ren and whether you have any issues with your pelvic floor (such as continence/prolapse/urgency):		

What are your main aims/goals for attending services delivered by Plus Health Company:

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Health Disclaimer:

By signing below, you are confirming you have given a true and thorough account of your health on this form and understand it is your responsibility to inform staff at Plus Health Company if there are any changes to your health, given they may affect your assessment, treatment and management options. You also agree to bring anything you are likely to need in order to optimally manage any known health conditions (ie inhaler for asthmatics) for all your attendances at Plus Health Company:

Signed …… Print …… Dated ……

Consent:

By signing below, you agree that if you feel unclear about any aspect of your consultation or classes, you agree to ask us for further information in order to reach an informed decision and give your consent (or not) in relation to your care/treatment options. **It is important you know and remember that you have the right to withdraw your consent at any time, without reason, for any aspect of your care, and we will respect your decision without prejudice.** Please note, we may be required to ask you to sign an additional form in this event but will inform you as such if required.

Signed …… Print …… Dated ……

Terms and Conditions/Privacy Policy:

By signing below, you are confirming you have read, understand and agree with our terms and conditions, as well as our privacy policy.

Signed …… Print …… Dated ……

Clinician use only: