THE CORE STUDIO LTD
MEDICAL SCREENING FORM

ALL DETAILS GIVEN ARE STRICTLY CONFIDENTIAL

First Name	Last Name

Address
D.O.B

Telephone Day/Evening/Mobile	Email Address

Do you now or have you in the past twelve months suffered any of the following?

CONDITION	YES	NO
Personal History of Heart Problems		
Family History of Heart Problems		
High Blood Pressure		
Low Blood Pressure		
Asthma or Other Respiratory Problems		
Personal History of Lung Problems		
Pain or Limited Movements in Any Joints		
Back Pain		
Epilepsy		
Diabetes		
Do You Smoke, If Yes How Many Cigarettes Per Day Do You Smoke?		
Are You Taking Any Prescribed Medication		
If Yes, Please Give Details Here:		
Are You Pregnant Or Do You Have A Child Under Six Months?		
If You Suffer From Any Communicable Disease Or Have Recently Had Any Surgical Procedure, Injury, Or Chronic Illness, Please Give Details Here:		
Current Fitness level or Activities: Ie: Beginner/Intermediate/Advanced Fitness. Please Circle. Brief description of injury/pain you are presenting with:		

I confirm that the information given above is true and accurate. I undertake this treatment/class session entirely at my own risk and will not hold the practitioner responsible for any injury howsoever caused in this respect. I have medical clearance for this treatment/class and have read and accepted the Terms and Conditions

Signature	Date