

# Medical waiver disclaimer



Client Ref No. \_\_\_\_\_

Name	Age	D.O.B
Address	.	
Town	Post Code	
Mobile No.	_____	
Home No.	_____	
e-mail address.	_____	

**Bodystats**

Height	Weight	Hydration %
BP	Glucose Minerals	Fat in weight
PH Test	BMR	

Occupation	Member of a Gym?
Company	Drs Name
Hours of work	Surgery Name
Days of work	Surgery Address

Food Likes/Dislikes \_\_\_\_\_

Exercise Likes/Dislikes \_\_\_\_\_

Present Activity \_\_\_\_\_

Goals \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Next of kin details**

Name	Relationship
Address	Mobile No
City	Postcode
	Home/Office No

\_\_\_\_\_

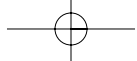
\_\_\_\_\_

Please which is appropriate to you.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Do you suffer back pain?                 | <input type="checkbox"/> Ever seen a dietician or nutritionist? | <input type="checkbox"/> Pregnant?                  |
| <input type="checkbox"/> Pressure point pain?                     | <input type="checkbox"/> Epileptic?                             | <input type="checkbox"/> Tension/soreness?          |
| <input type="checkbox"/> Do you smoke? Quantity?                  | <input type="checkbox"/> Ever had surgery?                      | <input type="checkbox"/> Numbness/stabbing pain?    |
| <input type="checkbox"/> Had advice to avoid an exercise?         | <input type="checkbox"/> High cholesterol?                      | <input type="checkbox"/> Frequent headaches?        |
| <input type="checkbox"/> Knocked unconscious or a head injury?    | <input type="checkbox"/> Any allergies?                         | <input type="checkbox"/> Fainting or dizziness?     |
| <input type="checkbox"/> Any heart conditions in self or family?  | <input type="checkbox"/> Cold hands or feet?                    | <input type="checkbox"/> Fatigue/lack of energy?    |
| <input type="checkbox"/> Do you live with a smoker?               | <input type="checkbox"/> Difficulty sleeping?                   | <input type="checkbox"/> Stiff/swollen/pain joints? |
| <input type="checkbox"/> Are you currently taking any medication? | <input type="checkbox"/> Broken any bones?                      | <input type="checkbox"/> Breathing Difficulties?    |
| <input type="checkbox"/> Do you drink coffee? Quantity?           | <input type="checkbox"/> High Blood Pressure?                   | <input type="checkbox"/> Diabetes in family?        |
| <input type="checkbox"/> Food sensitivities?                      | <input type="checkbox"/> Food Cravings?                         | <input type="checkbox"/> Can you swim?              |
| <input type="checkbox"/> Do you have any children?                | <input type="checkbox"/> Alcohol/week?                          | <input type="checkbox"/> Muscle/joint injury?       |
| <input type="checkbox"/> Are you on a special diet?               | <input type="checkbox"/> H2O/day?                               |   |

Tel: 07808 470031 [www.greengymcompany.co.uk](http://www.greengymcompany.co.uk)

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## Medical disclaimer cont.

1. What is your 'Chief complaint?  
\_\_\_\_\_  
\_\_\_\_\_
2. Please state how long you have had this complaint, when you first noticed it, and what incident you feel started it.  
\_\_\_\_\_  
\_\_\_\_\_
3. How does your chief complaint effect you on a day to day basis?  
\_\_\_\_\_  
\_\_\_\_\_
4. Are the symptoms brought on by certain activities or positions?  
\_\_\_\_\_
5. Do specific positions or activities alleviate your symptoms?  
\_\_\_\_\_
6. When is the pain worse?  
\_\_\_\_\_
7. On a scale of 1-10 (1=low 10=high) please rate the stress in your career.  
\_\_\_\_\_
8. On a scale of 1-10 (1=low 10=high) please rate the stress in your personal life.  
\_\_\_\_\_
9. Have you ever had any of the following treatments; physio, chiropractor, acupuncture, massage, other? (Specify)  
\_\_\_\_\_  
\_\_\_\_\_
10. Do you have an ergonomically set up desk?  
\_\_\_\_\_
11. How many hours do you spend in front of a computer?  
\_\_\_\_\_
12. What time do you usually go to bed?  
\_\_\_\_\_
13. What time do you wake in the morning?  
\_\_\_\_\_
14. How many meals do you eat each day? List time of day.  
\_\_\_\_\_
15. How many days do you have to commit towards working out?  
\_\_\_\_\_
16. Is there any specific parts of your body you wish to work on?  
\_\_\_\_\_  
\_\_\_\_\_

Trainers notes:  
\_\_\_\_\_  
\_\_\_\_\_

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Client Sign: \_\_\_\_\_ Date: \_\_\_\_\_ PT Sign: \_\_\_\_\_ Date: \_\_\_\_\_

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