Movement Foundations

Health Questionnaire

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How did you hear about Movement Foundations?

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1. Do you have any injuries, aches or pains? (Currently or Previously)

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1. Are you undergoing medical treatment or had previously medical treatment for any of the following conditions:

* Asthma
* Diabetes
* High Blood Pressure
* Other

If YES to any of the above, please provide further details:

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Note:  
If you answered yes to one or more of the above and have been inactive or are concerned about your health, consult a physician before commencing a fitness programme or substantially increasing your physical activity. You should ask for a medical clearance along with information about specific exercise limitations you may have.

1. Are you currently receiving treatment from an Osteopath, Physio or other similar therapist?

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1. Have you been pregnant or had a baby within the past year?

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1. What is your occupation?

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1. What are your goals and what do you hope to achieve from these workshops?

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1. Please detail other information you feel that we should know about you below:

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***Many thanks for your time in filling in this questionnaire.***