Medical Form

Full Name:

Date of birth:

Contact Number:

Email:

Address:

Postcode:

Please tick any that apply:

O Heart conditions/ Stroke

O Cancer/ Chemotherapy

O High/ Low blood pressure

O Diabetes (Type 1 or 2)

O Epilepsy

O Hepatitis

O Kidney/ Liver disorders

O Urinary Disorder

O Hormonal problems

O Skeletal problems

O Lymphatic problems

O Thyroid problems

O Circulatory problems

O Water retention/ Oedema

O Claustrophobia

O Bowel problems

O Joint problems/ Hyper mobility

O Muscular Pain

O Asthma

O Varicose Veins

O Thrombosis

O Migraines

O Back Problems

O Foot infections

O Pregnancy

O Depression/ Anxiety

Other:

Are you taking any medication? (This includes the contraceptive pills, HRT, and prescription drugs.):

Have you had any recent surgery, or accidents:

Have you had any other past illness?

Do you confirm that you have read and understood the consultation card and have answered the questions to your full knowledge and are happy to go ahead with the class and go ahead with the class without a doctors note (if needed). It is your responsibility and not that of the teacher to consult your GP or consultant. You agree that any partake in a class is done at your risk without limiting or affecting your statutory rights. Any dispute or claim that arises out of or is related to such service shall be subject to the law and exclusive jurisdiction of the courts of the country/region in which the relevant service took place. You consent to the use of your personal data for the purpose of your treatment.

I hereby indemnify Megan Smith against any adverse reaction sustained as a result of the class.

Client signature:_____

Date:_____