Health Questionnaire - Standard

Health history form

The following information is required for your health and safety.

This information will be treated in the strictest confidence.

Title: Mr/Miss/Mrs/Ms/Dr/Prof	
Forename:	Surname:
Address:	
Date of Birth:	Home Number:
Occupation:	Mobile Number:
Email:	
GP Name & Address:	

How did you hear about us?

Google search	
Other internet search	
Adwords Advert	
Facebook Page	
Flyer	
Word of mouth	
Attended previous workshop/class	
Other	Please state_________________________

Would you like to be added to our email list?	YES	NO
Have you ever participated in a Tai Chi/Dao Yin/Qigong class before?	YES	NO
Are you under the care of a chiropractor, physiotherapist, or other health practitioner?	YES	NO
If yes, please state which health professional and for what condition.		

Medical History – please complete

Question	YES	NO	Dates & Details
Are you pregnant or trying to get pregnant?			
Do you wear contact lenses?			
Migraine or headaches?			
Acute infectious disease? (e.g. TB, HIV, measles,etc)			
Recent head or neck injury (in the last 1 year)?			
Recent surgery (in the last 2 years)?			
Circulatory disorder?			
Blood clots/deep vein thrombosis/varicose veins?			
High or low blood pressure?			
Dysfunction of the nervous system (e.g. MS, Parkinson's, Moto Neurone Disease)?			
Cancer?			
Epilepsy?			
Diabetes?			
Rheumatism/Arthritis?			
Asthma?			
Muscular aches?			
Are you taking any medication or natural remedies?			
If yes, for what condition/name of medication?			
Are there any other issues we should be aware of?			

General Health?	Good	Fair	Poor
Illnesses?			
Operations?			
Accidents?			

Please ✔ or ✗ the ilness or ailment below and add details if necessary.			
Musculo-Skeletal Problems	Joint Pains?	Joint Stiffness?	
Cardio-Vascular Problems	Chest Pain?	Shortness Of Breath?	Smoker? How many a week?
Gastro-Intestinal Problems	Changes in bowel habits?	Constipation?	Diarrhoea?
Genito-Urinary Problems	Problems with passing/starting/stopping water?	Burning?	Changes in frequency?
Gynae Problems	Changes in menstrual cycle?	Pregnancy?	Menopause?
Eating Habits			
Fluid Intake			
Exercise			
Others			
How would you rate your current stress levels on a scale of 1 – 5, with 5 being the highest?		Home:	Work:

Use this space to let us know anything else that may be relevant? E.g. any special requirements, help with stairs etc.

Declaration – Please read & sign

I have completed this form to the best of my knowledge and have disclosed information about any condition that could be affected by exercise. I understand that Tai Chi, Dao Yin and Qigong are safe forms of exercise, but are not substitutes for conventional medicine or medical advice. I undertake to consult my doctor if I am unsure whether this form of exercise is for me, especially if I have problems with my spine, heart or joints or if I have any fractures, severe osteoporosis or am pregnant. I am aware that my participation in the class is by my own choice. I undertake to keep D.Ng Tai Chi updated on my health, should there be any changes to the answers given.

Print Name:	
Signature:	Date:

TEACHER USE ONLY				
Type of class attending?	TAI CHI	DAO YIN	QIGONG	
Date of first class				
More Info (if required):				
Teacher Initials:				