CLIENT HEALTH SCREENING FORM

Refer to the *Terms & Conditions* on our website thewhitewaystudio.com

Name _____ Date of Birth _____

Address _____

Contact No. _____ Email _____

Please answer the following questions as fully as possible to ensure that your workout is as safe and effective as possible.

Do you have any injuries, aches or pains?

Past _____

Current _____

Have you seen a doctor, Osteopath, Chiropractor Physiotherapist or any other healthcare professional regarding this condition? If so, what was their diagnosis?

_____

_____

Do you have any other health concerns? (e.g. asthma, diabetes, high blood pressure, osteoporosis...) _____

Have you been cleared by your doctor to start exercise classes? _____

Are you active in any other sports or exercise programme? _____

What do you want to achieve from this exercise programme? (e.g. flexibility, strength, posture...) _____

_____

What is you occupation? What does your typical day involve physically? (e.g. sitting at a computer, lifting...) _____

_____

EXERCISE SHOULD BE PERFORMED AT A PACE WHICH FEELS COMFORTABLE FOR YOU.
PAIN IS THE BODY'S WARNING SYSTEM AND SHOULD NOT BE IGNORED.

I _____ understand the above questions and have answered to the best of my knowledge. I agree that I am in good physical condition (except as stated above) and accept that I exercise at my own risk. I understand that whilst the utmost of care is taken I agree to hold the instructor harmless from and against any and all injuries, damage or losses resulting from training, accident or negligence.

Under the General Data Protection Regulations we need consent to contact you.
Preferred method of contact ☐ Landline ☐ Mobile ☐ Email
☐ I consent to be contacted by The Whiteway Studio. I understand I may withdraw my consent at any time.

Signed _____ Date _____