Health Screening Questionnaire.

Name ……D.O.B……..

Address……

Email ……..

Mobile…….Occupation……

Emergency Contact: ……..

Medical History:

Have you ever suffered from heart trouble?	Y/N
Do you ever suffer from chest pains?	Y/N
Are you presently taking any form of medication?	Y/N
Do you ever have spells of dizziness or feel faint?	Y/N
Have you ever had either high or low blood pressure?	Y/N
Do you suffer from high cholesterol?	Y/N
Have you suffer from asthma?	Y/N
Do you suffer from severe back pains or any orthopaedic problems?	Y/N
Do you suffer from headaches or migraines?	Y/N
Are you recuperating from a recent illness/operation or injury?	Y/N
Are you pregnant, if so how many months?	Y/N
Do you suffer from diabetes?	Y/N

Have you had COVID-19 and are still suffering from any longer-term symptoms resulting from COVID-19? Y/N?

If you have answered yes to any questions above, you are advised to seek medical advice/approval before commencing an exercise programme.

I have been informed that if I have answered yes to any of these questions, I should seek medical approval before commencing this exercise session. If I wish to continue without such advice I do so at my own risk. I confirm that I have fully understood the above questions and answered accurately.

I understand that One Body.Love it, or any of its employees cannot be held responsible for any injuries or ill health of any kind arising from attendance at a session, either in person, online class or individual training.

I consent to receiving newsletters and updates from One Body.Love it. Y/N

Signed: .....

Date: .....