HEALTH SCREENING FORM

NAME:……..

ADDRESS:……..

……

……

Contact Number:……

Email Address:……

Do you suffer from back problems?.....

If so, please give details:……...

Have you ever had treatment for a back problem?.....

If so, who are you receiving treatment from?.....

PHYSIOTHERAPIST / CHIROPRACTOR / OSTEOPATH if so please give name & phone number

Any other professional?.....

Have you been given medical clearance to attend Kick Start Fat Loss Bootcamp? (You should always seek medical advice when undergoing any new exercise plan).

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Are you suffering from any other medical problems that may affect your ability to exercise?

……..

Have you any additional health information that may be relevant?

……..

Have you had a child within the last 12 months?.....

How do you rate your overall fitness – give details?

Excellent **Average**

Poor **Very poor**

I understand that I attend Kick Start Fat Loss Bootcamp at my own risk.

Signed……..

Date……..