**Pre-Assessment Health Questionnaire**

**PLEASE COMPLETE IN CAPITAL LETTERS**

**Name:………………………………………………..….….. D.O.B………………………………….. G.P. …………………………………………….….**

How would you describe your General Health? ………………………………..…………………………………………………………………………………..……..

How much exercise do you do in an average week? …………………………………………………………………………………………………….………………

(Please specify time and what type of exercise)

**PLEASE CIRCLE YOUR RESPONSES TO THE QUESTIONS BELOW, AND STATE IF THE PROBLEM IS WITH YOURSELF, OR IF YOU HAVE A FAMILY HISTORY OF THAT CONDITION**

Do you feel tired all the time? Yes/No ………………………………….…………………………………………………… …………

**Have you ever had any of the following?**

* Previous accidents, injuries or operations? Yes/No……………………………………………………………..……………………..………….……
* Heart Condition? Yes/No……………………………………………………….……………………………….……...……
* High Blood Pressure? Yes/No……………………………………………………………………………….…….…….……..…
* High Cholesterol? Yes/No…………………………………….………………….………………………………………..….
* Breathing Problems? Yes/No………………………………………………………………….…..……………………...…….
* Cancer? Yes/No…………………...…………………………………………………….…………………….…..
* Osteoporosis? (Thinning of the bones) Yes/No………………………………………………………………………………………..…………..
* Previous Stroke? Yes/No………………………………………………………..………………………………….……….
* Thyroid Problems? Yes/ No……………………………………………………………………………………….……………
* Diabetes? Yes/No ……………………………………………………………………………………………..……..

If yes please circle Type 1/ Type 2

Is your diabetes: Well controlled/ Poorly controlled (please circle)

* Epilepsy? Yes/No…………………………….…………………………………………………….…..……………
* Diagnosed Arthritis? Yes/No…………………………………………………..………………………………………………..
* Gynaecological Problems? Yes/No…………………………………………………………..………………………………………..
* Do you visit the toilet more than once a night? Yes/No………………………………………………………….…………………………………….
* Allergies? Yes/No ……………………………………………………………………………………….……………

Do you have any of the following symptoms?

* Chest or Arm Pain? Yes/No……………………………………………………………………………..……………………
* Palpitations? Yes/No…………………………………………………………………………..………………………
* Shortness of Breath? Yes/No……………………………………………….……………………….…………………………
* Cramping in the Calves? Yes/No……………………………………………………………………..……………………………
* Persistent cough? Yes/No……………………………………………………………………..……………………………
* Broken Bones or previous operations? Yes/No……………………………………………………………………..……………………………
* Stiffness of your joints in the morning? Yes/No……………………………………………………………………..……………………………
* Pain at night and/or night sweats? Yes/No……………………………………………………………………..……………………………
* Unexplained changes in your weight? Yes/No……………………………………………………………………..……………………………
* Stomach complaints? Yes/No……………………………………………………………………..……………………………
* Skin problems? Yes/No……………………………………………………………………..……………………………

Have you ever taken blood-thinning tablets? Yes/No……………………………………………………………………..……………………………

Have you ever taken a course of steroid medication? Yes/No……………………………………………………………………..……………………………

Do you have a history of depression or anxiety? Yes/No……………………………………………………………………..……………………………

Have you ever been diagnosed with an eating disorder? Yes/No……………….…………………….……………………………………………….………

Do you smoke? Yes/No If yes, how many per day?……………………...........................……….….…………

Do you drink alcohol? Yes/No If yes, how much per week? ………………………………………………………….……..

Are you pregnant? Yes/No If yes, how many weeks? ……..……………………………………….…..………..……….

In order to help with advertising, please could you tell me how you found out about Rebecca Simpson Physiotherapy?

 Word of mouth  Village help

Google Towcester in Focus

GP Other (please state) ……………………………………….……………………….…….

*Thank you*