Posture Plus

Pre–Assessment Form

Name:_____ Age: _____

GP: _____ Referred by: _____

Do you have any of the following medical problems? (**Y/N**: if ***Yes*** please provide details)

Cardiac: Y/N _____

Respiratory: Y/N _____

Diabetes: Y/N _____

Back/neck: Y/N _____

Cystitis: Y/N _____

Smoker: Y/N _____

Allergies: Y/N _____

Others: _____

Are you taking any medication? **(Y/N)** If ***Yes*** please list:

_____

_____

Have you had any gynaecological/abdominal surgery? **(Y/N)** If ***Yes*** please list:

_____

_____

_____

_____

Have you had children? **(Y/N)** If ***Yes***, what type of deliveries:

_____

_____

_____

_____

Are you pregnant? **Y/N** Planning in the future **Y/N**

When was you last smear test? _____

Thank-you for completing this confidential form.

You may email the completed form to reception@posture-plus.com or bring it in with you to your first appointment.