5-ADDITIONAL RELEVANT INFORMATION

Have you had any recent investigations (X-ray/MRI-scans or blood tests)? results:_____
Do you have any relevant reports or referrals to provide us with relation to your treatment?_____
Is there a history of ill health (heart disease, cancer, diabetes) in your family?_____
Do you feel your diet provides you with adequate nutrition?_____
Please rate your level of stress at home? (0 no stress- 10 extremely stressed) : _____
Please rate your level of stress at work? (0 no stress- 10 extremely stressed) : _____
Intake of: cigarettes /day : ____ daily cups tea : ____coffee :____ weekly glasses of alcohol : ____

Terms and conditions:
The therapy service and subsequent treatment program we devise for you is based upon our sound teaching practice and the information you have provided about yourself when filling out this medical screening questionnaire. You must therefore inform us about any change in your medical condition as soon as you become aware of it. I accept the above terms and conditions and agree to abide by them:

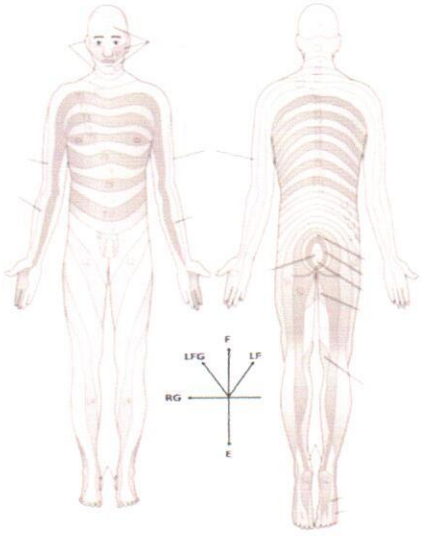
Signed:_____

Date:_____

PHYSICAL ASSESSMENT – Therapist only section

GLOBAL OBSERVATIONS

_____
_____
_____
_____
_____
_____
_____
_____



RESTRICTION AND INSTATBILITIES

_____
_____
_____
_____
_____
_____
_____
_____

SPINAL OBSERVATIONS

Static postural observations	Right	Left	Neutral/ normal	Dynamic postural observations	Right	Left	Neutral/ normal
Lateral cervical shift				Restricted cervical rotation			
Rotated cervical shift				Restricted cervical side flexion			
Lateral trunk shift				Restricted trunk rotation			
Trunk rotated in standing				Restricted trunk side flexion			
Trunk rotated in sitting				Deviation during lumbar flexion			
Scoliosis (concave)				Deviation during lumbar extension			