

Name: _____ DOB: _____ Date: _____

All information provided on this form will remain private and confidential. Please complete as fully as possible, circling your answer where appropriate, and bring to your Musculoskeletal Health Assessment.

Please shade in any areas of pain or discomfort that you may have on the diagrams below. If you feel any of these are exacerbated by posture at work, please indicate these by labeling them with a 'W'.

Right Side

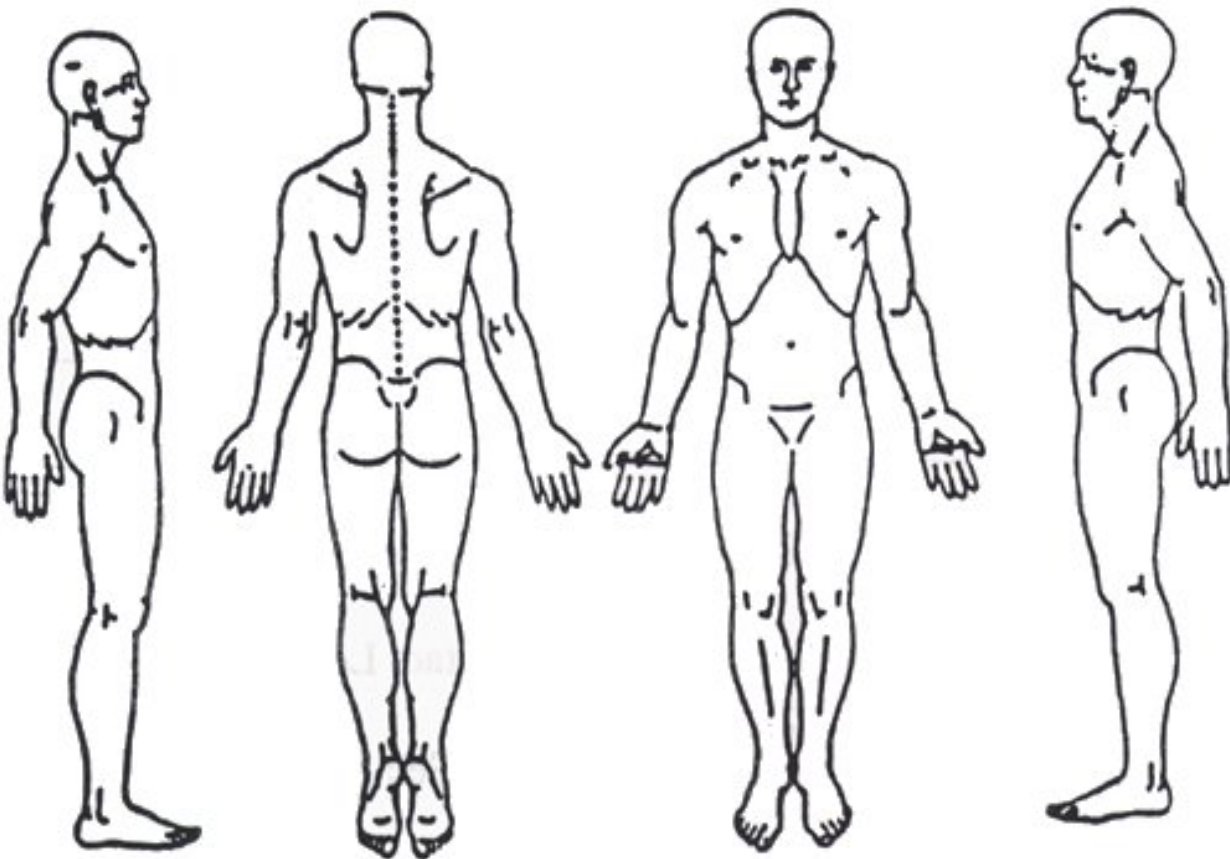
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Left Side



On this scale of 0 – 10, please grade any pain or discomfort by circling the appropriate box:

0	1	2	3	4	5	6	7	8	9	10
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Have you ever consulted your GP about any of the above areas of pain or discomfort? Y / N

If so, when did you last consult your GP?

Have you had any x-rays or scans for these? Y / N

If so, when were these taken?

Please indicate below if you currently suffer from or have previously suffered from any of the following:

Symptoms	Yes	No	Symptoms	Yes	No
Cancer (past / present)			Blurred vision		
Heart condition			Dizziness		
High blood pressure			Sinus problems		
Stroke			Ringing in ears		
Blackouts / faints			Abdominal pain		
Chest pain			Trouble urinating		
Chronic cough			Prostate problems		
Asthma			Menstrual problems		
Diabetes			Allergies		
Thyroid problems			Headaches		

Do you take any regular medications / supplements? Y / N

If yes, please indicate medication / dose / condition it's taken for:

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Have you ever taken steroids? Y / N

Have you ever taken anticoagulants (blood thinners)? Y / N

Have you had any broken bones? Y / N

Have you **EVER** had any surgery? Y / N

Have you **EVER** been in a road traffic accident? Y / N

Do you currently, or have you ever smoked? No / Yes in the past / Yes currently

Do you drink alcohol? Y / N

If yes, how many units per week? (Pint lager 5% = 2.8 units / 175ml glass of 13% wine = 2.3 units)

Has anyone in your immediate family (parents / grandparents / brothers / sisters) ever suffered from:

Cancer	Y / N	Stroke	Y / N	Heart problems	Y / N
Diabetes	Y / N	Arthritis	Y / N	Epilepsy	Y / N

Female Only

How many children do you have?

How many pregnancies have you had?

Are you currently pregnant? Y / N

If yes, how many weeks pregnant?

