



Ascent Personal Information

Confidential

Family Name:

First Name:

Date of Birth (Day/Month/Year):

Home address:

Home/Office telephone:

Mobile telephone:

Emergency contact name:

Emergency contact telephone:

Current Level of Fitness: Couch Potato, Semi-Active, Active, Very Active

Personal Medical History:

- | | | |
|----|---|--------|
| 1 | Have you ever experienced fits, seizures or head injuries? | YES/NO |
| 2 | Have you ever had an operation under general anaesthetic? | YES/NO |
| 3 | Have you been hospitalised within the last 12 months? | YES/NO |
| 4 | Do you have any allergies? | YES/NO |
| 5 | Do you suffer from Diabetes? | YES/NO |
| 6 | Do you have any history of mental health conditions? | YES/NO |
| 7 | Have you ever experienced any cardiac problems? | YES/NO |
| 8 | Have you ever experienced asthma or other respiratory problems? | YES/NO |
| | If yes to asthma: What medication/inhaler do you use? | YES/NO |
| | Have you ever needed steroid tablets? | YES/NO |
| | Have you ever needed medical attention? | YES/NO |
| 9 | Do you currently use any form of medication regularly? | YES/NO |
| 10 | Do you have any physical or other disability? | YES/NO |

If you answer 'YES' to any of the above then please give details and dates, including details of any family history of these conditions.

Please sign to confirm that this health history is correct to the best of your knowledge:

Client's Signature: Date:

IF ANYTHING TO DO WITH YOUR PHYSICAL OR MENTAL HEALTH CHANGES AFTER RETURNING THIS FORM, YOU MUST INFORM THE ASCENT STAFF.