**CourseTitle: ..................................................................................Date: .............................**

During this program, all participants are used as models for the practical sessions (under the supervision of table tutors).To enable us to best serve your needs during the course would you please fill out the following health questionnaire.

Please return the questionnaires by the date in the accompanying letter.

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| --- | --- |
| **Name:**  .................................................................................. | **Date of BIrth:**  .............................................................. |
| **Do you have any pain or discomfort at present?**  **Yes No** | If yes Please give details of symptoms: -  e.g. Onset, location, nature & cause if known.  .......................................................................................................................................................................................................................................................................................... |
| **Have you ever suffered facial or head trauma?**  **Yes No** | If yes please give details: -  .......................................................................................................................................................................................................................................................................................... |
| **Have you ever lost consciousness or been concussed?**  **Yes No** | If yes please give details: -  .......................................................................................................................................................................................................................................................................................... |
| **Do you suffer from headaches?**  **Yes No** | If yes please give details: -  e.g. Frequency, type, description.  .......................................................................................................................................................................................................................................................................................... |
| **Have you ever fractured any bones?**  **Yes No** | If yes please give details: -  e.g. location, type, when & how it occurred?  .......................................................................................................................................................................................................................................................................................... |
| **Have you been hospitalised in the past year?**  **Yes No** | If yes please give details: -  .......................................................................................................................................................................................................................................................................................... |
| **Have you ever had any major dental work?**  **Yes No** | If yes please give details: -  e.g. extractions, crowns, root canals,braces or plates  also when?  .......................................................................................................................................................................................................................................................................................... |
| **Have you ever suffered from any serious or chronic illnesses?**  **Yes No** | If yes please give details: -  e.g. chronic fatigue, hepatitis, auto-immune dysfunctions.    .......................................................................................................................................................................................................................................................................................... |
| **Do you have a history of cardiovascular problems eg hypertension, CVA?**  **Yes No** | If yes please give details: -  e.g. hypertension CVA.  .......................................................................................................................................................................................................................................................................................... |
| **Please list any medication you are currently taking or have ever taken for an extended period in the past.**  ......................................................................................................................................................................................................................................................................................  ………………………………………………………............................................................... | |
| ***During the course we explore particular aspects of cranial base function. Such a review may affect the pituitary gland. We also palpate the function of the sacrum and pelvis.***  **Therefore it would be helpful to know if you are currently pregnant.**  **If you are, have had any previous miscarriages?**………………………………………………………………………………………...............................................................................................................................................................…………………………………………………………………………………………................ | |
| **Is there anything else you would like to mention about your health?**………………………………………………………………………………………………….....…………………………………………………………………………………….……………....…………………………………………………………………………………………………..... | |

Thank you for your cooperation in filling in this questionnaire. Please be assured that this information will remain confidential and will only be viewed by your Table Tutors for each day and the Course Director. Following the Fundamentals Course, the information will be retained in a file by the Secretary of the SCTF of ANZ for the statutory period.