**Participant Details**

|  |  |
| --- | --- |
| Title |  |
| First name |  |
| Surname |  |
| DOB |  |
| Address |  |
| Postcode |  |
| Telephone |  |
| Email |  |

**Emergency Contact / Next of Kin**

|  |  |
| --- | --- |
| Title |  |
| Full name |  |
| Surname |  |
| Relationship |  |
| Address  (if different from above) |  |
| Telephone |  |
| Email |  |

**GP**

|  |  |
| --- | --- |
| Named GP |  |
| Practice Address |  |
| Telephone |  |
| Email |  |

**Page 1 of 2**

**Referrer details (if professional)**

|  |  |
| --- | --- |
| Full name |  |
| Role |  |
| Address |  |
| Telephone |  |
| Email |  |
| Summary of rehabilitation input received | *(please attach any relevant medical/ therapy reports)* |

**Neurological history**

|  |  |
| --- | --- |
| Neurological diagnosis |  |
| Date of diagnosis/start of symptoms |  |

**Current neurological difficulties**

***(select any that apply)***

|  |
| --- |
| Vision  Swallowing  Weakness in one arm  Weakness in one leg  Weakness in both arms  Weakness in both legs  Impaired balance  Increased tone / stiffness  Communication difficulties  Understanding difficulties  Memory difficulties  Attention / concentration difficulties  Fatigue  Pain |

**Other relevant medical history**

|  |
| --- |
|  |

**Medication (please list all currently taken)**

|  |  |
| --- | --- |
| Medication | Dose |
|  |  |

**Allergies**

|  |
| --- |
|  |

**Current Physical Activity Status**

|  |
| --- |
| How many times do you participate in moderate intensity exercise of over 30 minutes duration a week? (please tick)  Not at all  Once a week  Two to three times  Four to six times  Daily |

**Page 2 of 2**

**Goals for attending LEGS Exercise Group(s)**

|  |
| --- |
|  |

**Participant Consent**

|  |  |
| --- | --- |
| **I consent to join LEGS.**  **I consent to the LEGS physiotherapists contacting my medical practitioner as necessary for further details that will enhance my ongoing rehabilitation and safety to participate in exercise at home in an online group or in a studio session.** | |
| Name |  |
| Signed |  |
| Date |  |
| Please return this completed form to  Sarah Sparkes, Lead Physiotherapist: sarah.sparkes1@nhs.net | |