**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 toSarah Sparkes, Lead Physiotherapist: sarah.sparkes1@nhs.net |