PILATES ON TAY

Client Osteoporosis Risk Assessment Form

Name	**Date of Birth**
Address (including postcode)	**Telephone numbers:** Home Work/Mobile
Doctor's Name	**Doctor's Address**

All information given on this form will be kept in the strictest confidence

Please may we have a list of your medications to keep on record? This is not for diagnostic purposes. (Please include the dates you began the medication and the dosage)

Medication	Date started	Dosage

May we have a note of any supplements that you may be taking?

What are your exercise habits?

Have you been tested for Osteoporosis?

☐ Yes ☐ No

Please may we have a record of your results if they are known?

Please indicate 'no' or 'yes' on the following Osteoporosis risk factors' questionnaire

Are you a member of a non-black ethnic group	No	Yes
Do you have female relatives with Osteoporosis?	No	Yes
Have you had an early menopause – before the age of 40?	No	Yes
Are you short and thin?	No	Yes
Have you experienced amenorrhoea (lack of periods)?	No	Yes
Are your period's irregular?	No	Yes
Are you childless?	No	Yes
Do you have a Scoliosis?	No	Yes
Do you have a Kyphosis?	No	Yes
Are you lactose intolerant?	No	Yes
Are you on any sleep medications?	No	Yes
Do you have impaired vision?	No	Yes
Do you have any neurological impairment?	No	Yes
Do you have balance impairment?	No	Yes
Do you have a history of fractures?	No	Yes
Do you have a high alcohol use?	No	Yes
Do you have a high caffeine use?	No	Yes
If yes, how many cups per day ☐		
Do you smoke?	No	Yes
If yes, how many cigarettes per day? ☐		
Do you have a low Calcium diet?	No	Yes
Do you have a lack of Vitamin D?	No	Yes
Do you have a high salt diet?	No	Yes
Do you have a high protein diet?	No	Yes
Do you have chronic diarrhoea?	No	Yes
Do you have a regular use of steroids?	No	Yes
Do you use thyroid medications?	No	Yes
Do you take Aluminium-containing medications?	No	Yes

I, the undersigned, have filled in the form to the best of my knowledge. I understand that this is an assessment for and not a diagnosis. I understand that this is a tool to help the teacher understand more about my body and that he/she may recommend a follow-up appointment with my doctor.

Teacher taking assessment

_____	Print Name	_____	Print Name
_____	Signature	_____	Signature
_____	Date	_____	Date

Teachers Note: This form does not replace a client questionnaire form. Please ensure that the client has completed such a form