Consultation Form		
Please complete as fully as possible, if you are unsure about any question please ask your therapist.		
Date. Client name		DOB
Email address:		
Address		
Phone.	Mobile.	
Doctors name.	Surgery.	Phone.
Occupation.		
Emergency Contact Name		Phone
Exercise routine.		
Have you recently visited; doctor, consultant, physiotherapist, osteopath, sports therapist, chiropractor, acupuncture, massage, other?		
Are you currently seeing another practitioner?		
Are you currently taking medication? If yes, please list and state condition being treated:		
Main reason for attending.		
Is this as a result of specific incident or became apparent over a period of time.		
Any current problem or known history of the following ……		
Musculo-skeletal problems		yes / no
Arthritis, osteoporosis, fractures, joint replacement, pins or plates		yes / no
Heart, circulatory, arterial, blood pressure, feinting, vertigo, untreated thrombosis		yes / no
Thrombosis, embolism, varicose veins		yes / no
Diabetes, epilepsy, asthma, allergy		yes / no
Skin conditions, Erysipelas or cellulitis, Infectious skin diseases		yes / no
Cuts, bruises, burns, rashes, scars, warts, moles		yes / no
Pregnancies, caesarean sections		yes / no
Major /recent illnesses or Acute infections		yes / no
Major /recent operations		yes / no
Digestive, urinary, endocrine, respiratory, neurological problems		yes / no
Cardiac pacemakers or other electronic implants		yes / no
Hypersensitivity to electrostatic fields		yes / no
Specific aches and pains. Head, neck, upper back, lower back, hips, arms, hands, legs, feet?		
General sports injuries, accidents.		
General feeling; wellbeing, energy, normal diet, disrupted sleep, fatigue, depression, stress, smoke, drink.		
I confirm that the above information is correct to the best of my knowledge. If there is a change in my condition I will notify the therapist at the earliest opportunity. I understand that this therapy may involve a combination of techniques, including physical assessment, sports massage, remedial soft tissue techniques, heat and cold applications, electro-therapy, remedial exercise and development stretching. I understand that some techniques may be uncomfortable, and some techniques may cause bruising. (However the therapist will do their best to avoid this, and will respond to your feedback). I understand that all treatments will be explained to me, and I give my consent to the treatment provided.		
I consent to clinic administrative staff having access to this document, and agree to be contacted via		
Telephone		yes / no
Text / SMS / MMS	(not used for any marketing purposes)	yes / no
E-mail	(for aftercare advice information and sports therapy related information)	yes / no
Post	(for such things as receipts for your Health Insurance provider)	yes / no
Please note: Information is not shared with any Third-Party organisations		
These records will be kept for at least 7 years following the last occasion on which treatment was given. In the case of treatment to minors, these records will be kept for at least 7 years after they reach the age of majority (age 18).		
Client's signature;	Date	
Therapist's signature;	Date	