**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