**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

Postcode

Home Phone. Mobile.

Doctors name. Surgery.

Doctors Phone No.

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 ……… (if so, circle those which apply)

Musculo-skeletal problems **Y / N**

Arthritis Osteoporosis Fractures Joint Replacement Pins or plates **Y / N**

Heart Circulatory Arterial Blood Pressure Feinting Vertigo untreated Thrombosis **Y / N**

Thrombosis Embolism Varicose Veins **Y / N**

Diabetes Epilepsy Asthma Allergy **Y / N**

Skin conditions, Erysipelas or cellulitis, Infectious skin diseases **Y / N**

Cuts, bruises, burns, rashes, scars, warts, moles **Y / N**

Pregnancies, caesarean sections **Y / N**

Major /recent illnesses or Acute infections **Y / N**

Major /recent operations **Y / N**

Digestive Urinary Endocrine Respiratory Neurological problems **Y / N**

Cardiac pacemakers or other Electronic implants  **Y / N**

Hypersensitivity to electrostatic fields **Y / N**

If Yes, give details:

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.

**Specific to Covid-19**

There has not been any contact with anyone with Covid-19, in the last 14 days, to your knowledge **Y / N**

There have not been any symptoms: - dry cough, temp over 37.8°C, loss of smell and/or taste **Y / N**

Should the client contract the virus you must inform the therapist as soon as possible **- I Agree**

Should the client contract the virus we are obliged to inform NHS Track & Trace  **-** **I Understand**

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**

|  |
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| **Follow Up Appointments Checklist regarding Changes to Client Health****Name of Client:****Original Consultation Date:** |

|  |  |  |
| --- | --- | --- |
| **Date** | **Details of any changes to health (or NONE)** | **Signature** |
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