SPORTS THERAPY CONSULTATION FORM

Date:		
Client name:	DoB:	Age:
Address:		Height (m):
		Weight (kg):
Home Tel No:	Work Tel No:	Mobile Tel No:
Doctor name:	Surgery:	Tel No:
Occupation:		
Exercise routine:		
Have you recently visited: doctor/consult/physio/osteo/sporther/chiro/acup/pod/msg/other: Details:		
Are you currently taking any medications? Details:		
Main reason for attending:		
Any current problem or known history of the following: Musculo-skeletal problems: Arthritis; Osteoporosis; Fractures; Joint replacement; Pins and plates: Heart/Circulatory/Arterial/Blood pressure: Thrombosis/Embolism/Varicose veins: Diabetes/Epilepsy/Asthma/Allergy: Skin conditions: Cuts/Bruises/Burns/Rashes/Scars/Warts/Moles: Pregnancies: Major/Recent illnesses: Major/Recent operations: Digestive/Urinary/Endocrine/Respiratory/Neurological problems:		
Specific aches, pains, problems and injuries: Head/Neck/Thoracic/Lumbar/ Sacral/Coccygeal/Abdominal/Shoulder girdle/Upper arm/Elbow/Lower arm/ Wrist/Hand/Fingers/Pelvic girdle/Hip/Upper leg/Knee/Lower leg/Ankle/Foot/Toes		
General notes: accidents; sports injuries; headaches; migraines; vision; audition; olfaction; sinuses; fatigue; depression; sleep; stress; energy; well being; diet; fluid intake; smoking; alcohol.		
I confirm that the above information is correct to the best of my knowledge. If there is any change in my condition I will notify the therapist at the earliest opportunity. I understand that this therapy service may involve a combination of techniques, including: physical assessment; sports massage; remedial massage; heat and cold applications; electro-therapy; remedial exercise. I understand that all treatment methods will be explained to me, and I give my consent to the treatment provided.		
Client signature:		Date:
Therapist signature:		Date: