肌肉
jīròu

Highly Confidential

Sports Therapy Consultation Form

Client name	Age	DOB if U18
Email		
Phone	Postcode	

Daily activities, e.g. desk bound, on feet all day:

Exercise routine:

Have you recently visited a doc/consult/physio/osteo/ST/chiro/acup/msg etc. in the last 6 mths
With regards to the reason for this appointment or a relevant condition? Yes/ No

Are you currently seeing another practitioner? Yes / No
If yes, please sign to say that you have checked with them and that they have agreed that you can receive treatment from a Sports Therapist.
*signed*_____ *date:* _____

Reason for attending? (Is this as a result of a specific injury or did it become apparent over a period of time?)

Have you any other niggles?

Do you have any current problem or known history of the following:	
Musculo-skeletal problem, breech birth	Yes / No
Arthritis, osteoporosis, fractures, joint replacements, pins/plates, leg length discrepancy.	Yes / No
Heart, circulatory, arterial, blood pressure	Yes / No
Thrombosis, embolism, varicose veins	Yes / No
Diabetes, epilepsy, asthma, allergy	Yes / No
Skin conditions	Yes / No
Cuts, bruises, burns, sunburn, rashes, scars, warts, moles	Yes / No
Pregnancies, caesarian sections	Yes / No
Major illness, recent illness	Yes / No
Major operation, recent operation (in last 3 years)	Yes / No
Digestive, urinary, endocrine, respiratory, neurological problems	Yes / No
Are you currently/ have recently been taking any medication? *Relevant details:*	Yes / No
Have you had any general sporting injuries or accidents in the past? E.g. sprained ankle *Details*	Yes / No

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 may involve a combination of techniques, including physical assessment, sport and remedial massage, soft tissue techniques, heat and cold applications, electro-therapy, remedial exercise and development stretching. I understand that all treatments will be explained to me, and I give my consent to the treatment provided. (NB: Some forms of treatment are regarded as uncomfortable, however you remain in control and can stop the treatment at any time.) I understand that some treatments may result in contra-actions which include bruising, folliculitis, dehydration and drowsiness.

Client's signature: Date:

I consent to my data being processed (e.g. to be stored, be used to inform my treatment plan) in accordance with Jirou's Privacy Policy.

Client's signature: Date: