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Sports Therapy Consultation Form

Client name	DOB	Age
Email	Phone	
Address		
Doctor's name/surgery		Phone
Occupation		
Exercise routine		
Have you recently visited a doc/consult/physio/osteo/ST/chiro/acup/msg etc. in the last 6 mths or are you currently seeing another practitioner? *Details:*		Yes / No
Are you currently/ have recently been taking medication? *Details:*		
Main reason for attending? (Is this as a result of a specific injury or did it become apparent over a period of time?)		
Any current problem or known history of the following:		
Musculo-skeletal problem, breech birth		Yes / No
Arthritus, 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
Do you have any other specific aches and pains? Head, neck, upper back, lower back, hips, legs, feet, arms, hands		
Have you had any general sporting injuries, accidents in the past? *Details:*		
General: Wellbeing, depression, stress, energy levels / fatigue, diet, sleep patterns, BMI		

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 contractions which include bruising, folliculitis, dehydration and drowsiness.

Client's signature Date:

Therapist's signature Date: