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
Have you had any contact with anyone with Covid-19, in the last 14 days, to your knowledge **Y / N**
Have you had any symptoms: - dry cough, rash, 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**

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