

SPORTS THERAPY CONSULTATION FORM

Sarah Bray - VTC3

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/sporthr/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: