

Date:		
Client name:	Sex:	Age:
Address:		Weight (kg):
		Weight (lbs):
Home Tel no:	Work Tel no:	Mobile Tel no:
Doctor name:	Surgeon:	Tel no:
Occupation:		
Previous medical:		
Have you recent to visit a doctor/consult a physio/other health care provider/visit a clinic/visit a hospital/visit a specialist?		
Details:		
Are you currently taking any medication?		
Details:		
Main reason for attending:		
Any current problems or known history of the following:		
Musculoskeletal problems:		
Arthritis/Osteoporosis/Fracture/ Joint replacement/ Pins and plates		
Heart/Circulatory/Vascular/Blood pressure:		
Thrombosis/Embolism/Vascular issue:		
Diabetes/Epilepsy/Asthma/Allergy:		
Skin conditions:		
Cardiac issues/Burns/Scalds/ Burns/Flu/Influenza:		
Pregnancy:		
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Hypertension/operations:		
Digestive/Injury/infection/Respiratory/Neurological problems:		
Spinal cord issues, pain, problems and injuries Head/Neck/Shoulder/Elbow/		
Wrist/Ankle/Finger/Thumb/Hand/Upper limb/Shoulder/Upper arm/		
Lower limb/Ankle/Finger/Thumb/Hand/Upper limb/Shoulder/Upper arm/		
General issues, accidents, sports injuries, head/neck, injuries, vision, asthma, allergies, chronic fatigue, depression, sleep, stress, energy, self-harm, diet, diet intake, smoking, alcohol.		
I am aware 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 should only be used as a combination of therapies 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 for the treatment provided.		
Client signature:	Date:	
Therapist signature:	Date:	

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Forde, Susie H. VanHuss, Donna L.
Woo, Linda Hefferin**

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