**FIT4PURPOSE - SPORTS MASSAGE THERAPY CONSUTATION FORM**

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| Client Name: | | | | | | | |
| Date: | | | DOB: | | | Age: | |
| Address: | | | | | Email: | | |
| Home Tel: | | Work Tel: | | | | Mobile No: | |
| Doctor | | Surgery: | | | | Tel No: | |
| Occupation: | | | | | | | |
| Reason for attending: | | | | | | | |
| What are you hoping will be achieved from the session: | | | | | | | |
| Exercise Routine – Type, duration? | | | | | | | |
| Do you have a stretch routine/ what does this consist of: | | | | | | | |
| Are you currently taking any medication?  Details: | | | | | | | |
| Any current problem or known history in the following (please tick those that apply and provide more details in the information box below): | | | | | | | |
| Muscular-skeletal problems? | | | | | | | |
| Arthritis, osteoporosis, fractures, joint replacement, pins & plates? | | | | | | | |
| Thrombosis, Embolism, Blood clots, Varicose veins? | | | | | | | |
| Diabetes, Epilepsy, Asthma, Allergy? | | | | | | | |
| Digestive, Urinary, Endocrine, Respiratory, Neurological problems? | | | | | | | |
| Any Skin Conditions? | | | | | | | |
| Could you be pregnant? | | | | | | | |
| Do you feel well? | | | | | | | |
| Major or Recent operations? | | | | | | | |
| Have you had any sports injuries, headaches, migraines, vision impairment, sinuses, fatigue, depression, sleep disorder, stress? | | | | | | | |
| Do you smoke | No per day | | | Do you drink alcohol | | | Units per week |
| How much water do you consume per day: | | | | | | | |
| Have you had any form of massage therapy in the past:  Details: | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please circle the area that you are feeling the discomfort or pain and what makes it better or worse: | | | | | | | | |
| Anterior  head neck thoracic lumbar sacral coccygeal shoulder-girdle upper arm elbow lower arm wrist hand fingers pelvic-girdle hip upper-leg knee lower-leg ankle foot toes | | | | Posterior  head neck thoracic lumbar sacral coccygeal shoulder-girdle upper arm elbow lower arm wrist hand fingers pelvic-girdle hip upper-leg knee lower-leg ankle foot toes | | | | |
| Pain Scale | | | | | | | | |
| 0 | 1-2 | 3 | 4-5 | 6 | 7-8 | | 9 | 10 |
| none | just | mild | moderate |  | difficult to function | |  | unbearable |
| I can 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, sport & remedial massage and I give consent to the treatment provided.  I understand that this massage is not a replacement for medical care and no diagnosis will be made.  I am responsible for paying for any appointment cancellation of less than 24 hrs.  I consent to you creating and storing medical records concerning my treatment. I understand that this may include details concerning medication, treatment and other issues affecting health conditions, in accordance with the General Data Protection Regulation (GDPR) | | | | | | | | |
| Client Signature: | | | | | | Date: | | |

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| Clinic Notes |