FIT4PURPOSE - SPORTS MASSAGE THERAPY CONSUTATION FORM

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:			

Please circle the area that you are feeling the discomfort or pain and what makes it better or worse:

Anterior	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	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:

Clinic Notes