

The Sports & Fitness Clinic

Confidential Client Consultation Form

Contact Details

name: _____ gender: male / female
 address: _____
 contact numbers: (day) _____ (evening) _____

Person to contact in case of an emergency

name: _____ phone: _____

GP Details

name: _____ phone: _____
 surgery address: _____

Lifestyle Details

occupation: _____ lifestyle: _____
 special considerations: _____

Medical History

Please complete the section below ticking 'yes' or 'no' as appropriate. If you answer 'yes' to any please supply further information

Condition	yes	no	Condition	yes	no	Condition	yes	no	Condition	yes	no
impetigo			burns			low blood pressure			sinusitis		
lice and mites			severe bruising			high blood pressure			multiple sclerosis		
herpes simplex			open cuts / wounds			atherosclerosis			Parkinson's disease		
athletes foot			fractures			heart condition			HIV / AIDS		
ringworm			acute strain / sprain			diabetes			pneumonia		
warts / verrucas			bursitis			haemophilia			recent surgery		
severe eczema			osteoarthritis			cancer			fever		
psoriasis			varicose veins			lymphangitis			undiagnosed lumps		
dermatitis			glandular fever			systemic oedema			substance abuse		
severe acne / boils			thrombosis			tuberculosis			Raynaud's disease		

Details:

Has permission been given by your GP for treatment to be carried out?

Y N

Have you visited your GP in the last 6 months?

Y / N Details _____

Are you on any prescribed medication?

Y / N Details _____

Are you receiving treatment from another professional?

Y / N Details _____

Do you suffer from allergies?

Y / N Details _____

Do you have any condition other than those listed above?

Y / N Details _____

I hereby confirm that the information above is accurate to the best of my knowledge.

I undertake to inform the Therapist of any changes to the above information and I understand that this is essential to my safety.

Signed:

Date: