Client Record

Client Details

(Mr/Mrs/Miss/Ms)…………………Surname……………………………………First Name…………………………………..

D.O.B……………………....M/F……………………………… Height………………………Weight…………………………..

Address……

Contact Numbers: Day……………………..…………Eve…………..……………………Mobile……..……………………………

In case of an emergency contact:

Name...……………………..……...………Contact Number ……………………….…….Relationship………………………

Client Lifestyle Details

Occupation ……………………………………….… …………………Full/Part time…………………………………………..

Hobbies/interests/activities ……………………………………………………………………………………………...

Physically related work activities …………………………………………………………………………………………….

GP Details

Name ……………………………………….…………..Contact Number ………………………………………………………

Surgery Address……

Medical History

Do you have, or have you had in the past 6 months, any of the following symptoms/conditions?

Observable contraindications	y/n	GP contraindications	y/n	Precautionary conditions	y/n
skin disorders myositis recent operations inflammation sprains and strains cuts and bruises fractures phlebitis bursitis varicose veins burns		cancer cardiovascular disease diabetes (if not fully controlled) epilepsy disorders of the nervous system disorders of the lymphatic system auto immune disorders HIV and AIDS severe hypertension/ hypotension (if not fully controlled) thrombosis (DVT) neural disorders pneumonia substance abuse		medically weak skin, bone, tissues haemophilia pregnancy undiagnosed musculo-skeletal disorders menstruation diabetes (if client controlled) severe hypertension/ hypotension (if client controlled) asthma allergies headaches sinusitis	
airborne infections general fever glandular fever undiagnosed lumps unstable pregnancy					

Details……

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If required, has permission been given by the GP/Consultant to carry out the treatment? (please attach letter) 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 healthcare professional? y n Details………………………………………………..

Do you suffer from any allergies? y n Details………………………………………………..

I hereby confirm that the information stated above is accurate to the best of my ability. I further fully understand that thorough and honest responses to these questions are essential to my safety. I undertake to inform my therapist of any changes to the above information.

Signed……………………………………………………………………………… Date………………………

I understand that an assessment needs to take place in order to establish a treatment plan. All assessment and treatment procedures have been thoroughly explained and I am happy to proceed.

Signed……………………………………………………………………………… Date………………………

Therapist Signature ………………………………………………………….…. Date……………………….