SPORT
MASSAGE THERAPY
STEVE HOLDER

Consultation Form

PERSONAL DETAILS

Name: ………………………………………………………… DOB: ……………………………………

Address:………………………………………………………………………………………………
………………………………………………………………………………………………………

Preferred contact number: ………………………………………………………………………

Email: ………………………………………………………………………………………………

Occupation: …………………………………………………………………………………………

Doctors Address: ………………………………………………………………………….
………………………………………………………………………………………………………

Emergency contact number: ………………………………………………………………………

LIFESTYE DETAILS

If you exercise please state what exercise/sports you do …………………………………………..
………………………………………………………………………………………………………

How often do you exercise? ………………………………………………………………..………

How would you describe your stress level (1 low- 10 high) …………… energy level ………………...

What is your daily fluid intake, ltrs per day? ……………………………………………………….

Where do you think tension manifests itself in your body? ………………………………………………
………………… …………………………………………………………………..…………………..

What do you want to achieve from having treatment?…………………………………………………
……………………………………………………………………………………………..…………

MEDICAL DETAILS (Please answer Y/N and provide details if space given)

Are you currently under care of a doctor/practitioner? ………………………………………………...
……………………………………………………………………………………………………..

Are you currently on any medication? ……………………………………………………………..
……………………………………………………………………………………………………..

Have you had any recent injuries (in the last 12 months)? ……………………………………………
……………………………………………………………………………………………………..

Have you had any surgery in the last 12 months? ……………………………………………………..

Do you have any of the following, please list anything else for consideration:

Allergies ………. Asthma ……….. Diabetes ……….

Epilepsy ………. Arthritis ………. Cardiac Problems ………..

Poor Circulation ………. Skin Disorders ……….. Varicose Veins ………….

Spinal problems ………. Scar Tissue ……….. Infection/fever/virus ……….

High BP ………… Low BP ………. Pregnant …………

Implants …………….. Thrombosis…………

THERAPISTS NOTES

Marketing Preferences

Your personal information will only be used for treatment purposes and will not be shared with any third parties, without your express permission.

Keeping in touch

I would like to get intouch with you when I have information about new therapies & special offers that I think might be of interest to you. If you agree to being contacted in this way, please tick how you are happy to be contacted:

Email ○ SMS Text ○

Please get in touch if you would like these preferences changed at any time

Client Declaration

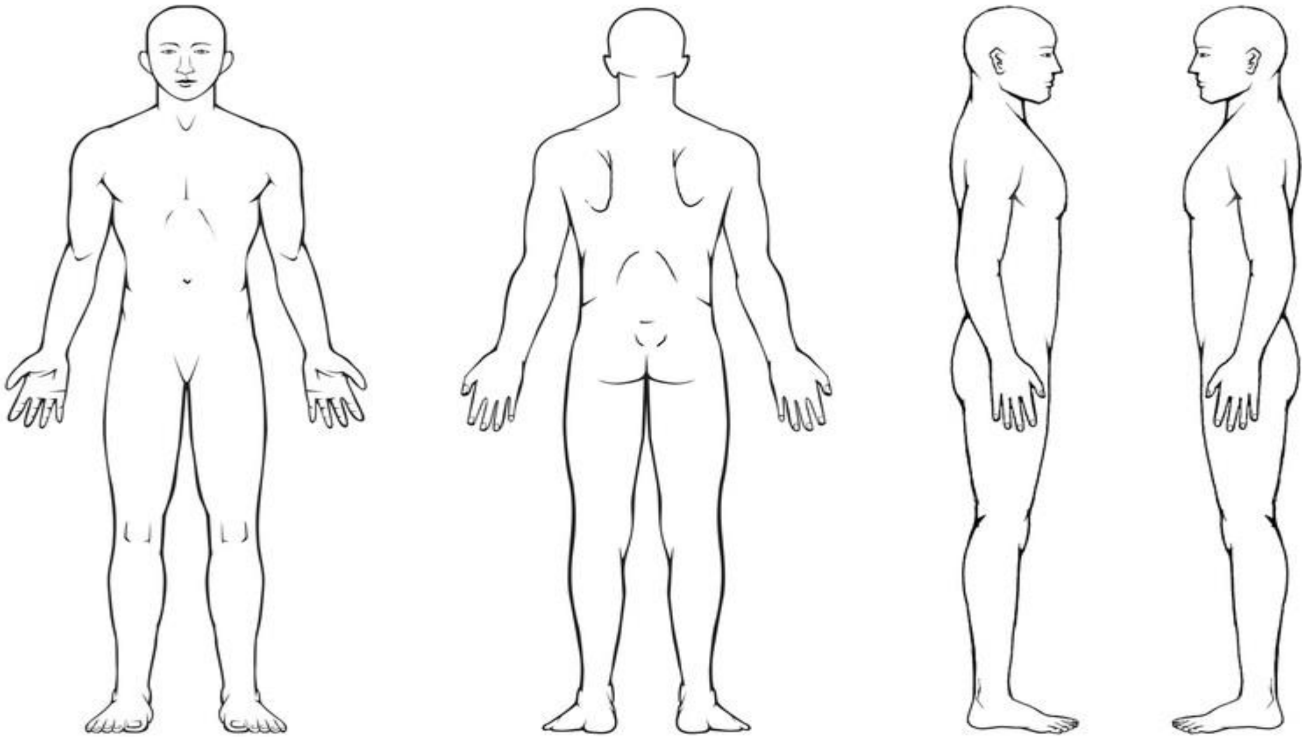
I declare that the information I have given is true and correct to the best of my knowledge, and that I can undertake treatment without any adverse effects. I have been fully informed about contra-indications & willing, therefore, to proceed. This information is confidential and will only be shared with my permission. If there are any changes I will notify the therapist.

I hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment.

Client Signed……………………………………..Date……………………………………………...

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

POSTURAL/ROM ASSESSMENT



SPECIAL TESTS

Area/Test ...…………………………………………………………………………………………………

Outcome……………………………………………………………………………………………………

Area/Test……………………………………………………………………………………………………

Outcome……………………………………………………………………………………………………

Area/Test ………………………………………………………………………………………………...

Outcome..………………………………………………………………………………………………...

CONCULSION/TREATMENT PLAN/ HOME CARE ADVICE
Therapist signature………………………………………………………………….. Date ………………..

Follow Up Consulation