Client Record Form

Client Details

(Mr/Mrs/Miss/Ms) _____ Surname _____ First Name _____

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

Address _____

Contact number: Day _____ Eve _____ Mobile _____

E-mail address: _____

In case of emergency contact:

Name _____ Contact number: _____ Relationship: _____

Client Lifestyle Details

Occupation _____ Full/Part-time _____

Hobbies/interest/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?

Contraindications					
Obsarvable	**Y/N**	**GP referral**	**Y/N**	**Precautionary conditions**	**Y/N**
Skin disorders		Cancer		Medically weak skin, bone, tissues	
Myositis		Cardiovascular disease		Heamophilia	
Recent Operations		Diabetes(severe ,not controlled)		Pregnancy	
Inflammation		Epilepsy		Undiagnosed musculoskeletal disorders	
Sprains and strains		Disorders of the nervous system		Menstruation	
Cuts and bruises		Disorders of the lymphatic system		Diabetes(if client controlled)	
Fractures		Autoimmune disorders		Severe hyper/hypotension(if client controlled)	
Phlebitis		HIV and AIDS		Asthma	
Bursitis		Severe hypertension/hypotension,not controlled		Allergies	
Vericose veins		Thrombosis(DVT)		Headaches	
Burns		Neural disorders		Sinusitis	
Airborne infections		Pneumonia			
General fever		Substance abuse			
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 there questions are essential to my safety. I undertake to inform my therapist of any changes to the above information.

Signed.....Date.....

I understand that the assessment needs to take place n 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.....