SPORTS THERAPYCONSULTATION FORM
Sarah Bray-VTC3

Date:

Client name: DoB: Age:

Address: Height (m):

Home Tel No: Work Tel No: Mobile Tel No:

Doctor name: Surgery: Tel No:

Occupation:

Exercise routine:

Have you recently visited:
doctor/consult/physio/osteo/sportherapist/chiro/acup/pod/msg/other: Details:

Are you currently taking any medications?
Details:

Main reason for attending:

Any current problem or known history of the following:

Musculo-skeletal problems:
Arthritis; Osteoporosis; Fractures; Joint replacement; Pins and plates:
Heart/Circulatory/Arterial/Blood pressure:
Major/Recent illnesses: Cancer
Major/Recent operations:
Thrombosis/Embolism/Varicose veins:
Diabetes/Epilepsy/Asthma/Allergy:
Skin conditions:
Neurological problems:
Digestive/Urinary/Endocrine/Respiratory/
Cuts/Bruises/Burns/Rashes/Scars/ Warts/Moles:
Pregnancies:

***ABOUT* Sports Massage** - The pressure needed to successfully treat muscular pain can sometimes cause discomfort and may result in bruising. It is normal to feel discomfort / mildly bruised in the 1-3 days following a sports massage, due to the lactic acid being flushed out of the congested tissues. Clients are requested to communicate fully with Sarah Bray at all times, during the massage, advising of their pain levels and pressure increase / decrease as required.

Massage pressure preferred: - GENTLE MEDIUM FIRM

I 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 before any subsequent treatments.

*I understand that this therapy service may involve a combination of techniques, including: physical assessment; sports massage; remedial massage; heat and cold applications; electro-therapy; remedial exercise. I understand and accept ***ABOUT*** sports massage, as detailed above and I give my consent to the treatment provided.*

Client signature: Date:

Therapist signature: Date: