PAGE 1 OF 4 - TO BE COMPLETED BY CLIENT 24 HRS PRIOR TO TREATMENT

Treatment will not proceed until the form is complete and has been discussed with your practitioner.

EXETER SPORTS MASSAGE

CLIENT ASSESSMENT

sta sports therapy association

Julie Duff
Sports Massage Therapist

Bellever, 8 Countess Wear Rd, Exeter, Devon, EX2 6LG. Mobile: 07770 768439 Email: exetersportsmassage@gmail.com

REASON FOR VISIT:

CLIENT HOPES AND EXPECTATIONS OF TREATMENT:

CLIENT DETAILS:

Title (Mr, Mrs etc) : Date of treatment: ☐☐ ☐☐ ☐☐

First Name: Surname:

Address:

Post Code:

Contact Number(s):

Email:

Occupation:

Date of Birth: D D M M Y Y GP Practice:

I am ◯ right ◯ left handed.

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GENERAL HEALTH

How would you describe your general health?

Please tick one box: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you taking any medication? Yes No If Yes please provide details in box below:

Have you had any recent surgery in the past 18 months? Yes ◯ No ◯ If Yes please provide details in box below:

How would you describe your level of physical activity? (This includes walking and gardening):

Have you had Sports Massage, Physiotherapy, Osteopathy or Chiropractic treatment before? if so, when:

How would you rate your current level of stress at the moment?

Please tick one box: ☐ Low ☐ Moderate ☐ High ☐ Very High

How would you describe your energy level today?

Please tick one box: ☐ Low ☐ Average ☐ High

Are you having difficulty sleeping at the moment?

◯ Yes ◯ No

Hours of sleep per night:

Anything else of relevance that you think I need to be aware of?

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CONTRAINDICATIONS - Musculoskeletal

Fractures	Yes ◯	No ◯
Strains/Sprains	Yes ◯	No ◯
Inflammation	Yes ◯	No ◯
Osteoporosis	Yes ◯	No ◯
Osteoarthritis	Yes ◯	No ◯
Rheumatoid Arthritis	Yes ◯	No ◯

If Yes to any of the contraindications please provide details below:

CONTRAINDICATIONS - Respiratory

Common Cold	Yes ◯	No ◯
Pneumonia	Yes ◯	No ◯
Tuberculosis	Yes ◯	No ◯
Sinusitis	Yes ◯	No ◯

If Yes to any of the contraindications please provide details below:

CONTRAINDICATIONS - Circulatory System

Varicose Veins	Yes ◯	No ◯
Thrombosis/Embolism	Yes ◯	No ◯
Atherosclerosis	Yes ◯	No ◯
Hypertension	Yes ◯	No ◯
Hypotension	Yes ◯	No ◯
Heart Failure	Yes ◯	No ◯
Severe Diabetes	Yes ◯	No ◯
Haemophilia	Yes ◯	No ◯
Oedema/Swelling	Yes ◯	No ◯
Lymphangitis	Yes ◯	No ◯

If Yes to any of the contraindications please provide details below:

PAGE 4 OF 4 - TO BE COMPLETED BY CLIENT 24 HRS PRIOR TO TREATMENT

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CONTRAINDICATIONS - Skin

Contagious Skin	Yes ◯	No ◯
Non Contagious	Yes ◯	No ◯
Neoplastic	Yes ◯	No ◯
Injuries	Yes ◯	No ◯

If Yes to any of the contraindications please provide details below:

CONTRAINDICATIONS - Nervous System

Sciatica	Yes ◯	No ◯
Multiple Sclerosis	Yes ◯	No ◯
Parkinsons	Yes ◯	No ◯
Shingles	Yes ◯	No ◯
Epilepsy	Yes ◯	No ◯
Stroke	Yes ◯	No ◯

If Yes to any of the contraindications please provide details below:

CONTRAINDICATIONS - Miscellaneous

Cancer	Yes ◯	No ◯	
Post Op	Yes ◯	No ◯	
Drunk Alcohol or taken drugs (last 24 hours)	Yes ◯	No ◯	
Undiagnosed lumps/bumps	Yes ◯	No ◯	
HIV/AIDS	Yes ◯	No ◯	
Pregnancy	Yes ◯	No ◯	N/A ◯

If Yes to any of the contraindications please provide details below:

CLIENT CONSENT

I have understood the questions asked above. To the best of my knowledge the answers given are correct and I give consent for treatment.

Name:

Date: D D M M Y Y