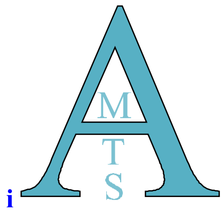

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CONSULTATION FORM

Name: ______________________ Tel No (Work):___________ Tel No (Home)__________ Mobile: ________________

Email: _______________________ Date of Birth:_____________ Occupation: __________________________________

Address:____

Doctor's practice and telephone number: ____

Reason for this visit: ____

Is your condition as a result of an accident?_____________Is litigation involved? ___________________________________

When did this condition start? ____

Have you had an X-ray or scan for this condition? If so give date(s) of scan/X-Ray and findings:
____

____

Have you received previous treatment for this condition?____

If so what, by who and when?____

Medical History:

Current:

Are you attending your doctor? *If yes please explain reason for recent visits* ____

____

Please tick any of these conditions that apply to you:

	Infections		Bereavement		Dental work		Pregnancy
	Heart Conditions		Depression/Anxiety		Headaches		Period Problems
	Blood Clots		Sleep problems		Migraine		Varicose Veins
	Chest pain		Weight Loss		Neck Pain		Urinary Problems
	High Blood Pressure		Diarrhoea		Sinusitis		Breathing Problems
	Low Blood Pressure		Constipation		Implants/stents		Asthma
	Dizziness		Indigestion		Allergies		Diabetes
	Ear Conditions		Cancer		Skin Problems		Epilepsy
	Pins &Needles/ Numbness		Lymph Node Removal		Difficulty Swallowing		Arthritis

Please give any other conditions not listed: ____

____

If pregnant please state date baby due: ____

Please list date of birth of all children (females only): ____

Please list conditions for which medication is being taken: ____

____

____

Previous Medical History:

Please list all accidents/fractures that you have had, with dates, stating whether or not an X-Ray/scan was taken and the results:

Please list all operations that you have had, with dates:

Next of kin: Relationship:

Tel No:

I have stated all my known medical conditions, in confidence, and take it upon myself to keep you updated on my physical health. I consent to this consultation, assessment and treatment which will involve soft tissue techniques.

Signature: Date:

For Use by Therapist

PRIMARY COMPLAINT:

Details of Previous Treatment:

Any other complaints:

Details of Health Problems, Relevant Accidents/Fractures and Operations from Overleaf:

Any Other Relevant History (including Stress Levels and Sport/Exercise):