CONSULTATION FORM

Todays' date

Name | Date of birth | Age

Address | Occupation

G.P. contact details

Post code

Telephone number | Mobile number

E-mail address | How referred

Medical history (please give dates)

Surgery/operations

Fractures

Accidents

Current medication, prescription over the counter and alternative supplements

Have you been referred for further investigation, out-patient, physiotherapy or other therapy by your GP ? If so what and when?

Do you have, or have you ever suffered with, any of the following? (Please tick all that apply).

- ❑ circulatory disorder
- ❑ respiratory disorder
- ❑ heart condition
- ❑ high/low blood pressure
- ❑ thrombosis
- ❑ dizzyness
- ❑ blackouts
- ❑ dental complaints
- ❑ varicose veins
- ❑ epilepsy
- ❑ diabetes
- ❑ abdominal complaint
- ❑ skin disorder
- ❑ bowel complaint
- ❑ bladder complaint
- ❑ visual disturbancies
- ❑ allergy
- ❑ arthritis
- ❑ osteoperosis/osteopenia
- ❑ nervous system disorder (MS, stroke)
- ❑ headaches
- ❑ ringing in the ears
- ❑ eating disorders
- ❑ a potentially fatal condition

General

Height Weight Special diet Smoker? Yes / No Nbrs. daily

How much water do you drink? /day Alcohol consumption light / moderate / heavy

Sport/exercise/relaxation

How would you describe your stress levels? high / moderate / low

What are your expectations of this treatment?

YOUR PRIMARY REASON FOR RECEIVING TREATMENT

What is your primary complaint?

When and how did this complaint start?

How does this complaint affect you?

Is this a recurrence of an old injury? (if yes please state when) yes no

Please indicate your current level of discomfort? Please circle where 10 is the worst and 0 is the best

0 1 2 3 4 5 6 7 8 9 10

What is the worst level of intensity you have had with your primary complaint? Please circle where 10 is the worst and 0 is the best.

0 1 2 3 4 5 6 7 8 9 10 Please state when this was

What, if anything, increases your pain/discomfort?

What, if anything, decreases your pain/discomfort?

MORE ABOUT YOUR PRIMARY REASON FOR RECEIVING TREATMENT

How often does your pain/discomfort occur on a normal day? Please circle where 10 is constant and 0 is never.

Never 0 1 2 3 4 5 6 7 8 9 10 constant

At what time of day is your pain/discomfort at its worst? Please circle those which apply

On waking mid day evening before bed during the night

To what extent is your daily functional ability hindered, as a percentage, due to your pain/discomfort? Please circle where 0% is the worst and 100% is the best

On a good day. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

On a bad day. 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Have you had any previous treatment for this complaint before, If so what was it and what was the outcome?

Have you had any X-rays, tests or MRI's? If so what were the results? yes no

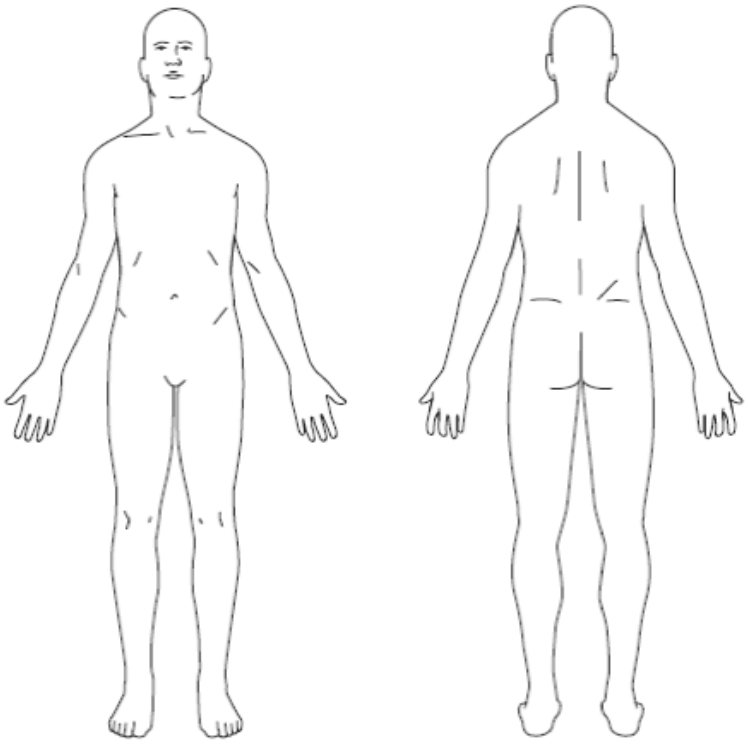
If you are employed, how many days have been absent from work for this pain/discomfort?

Please indicate any other information that you feel is relevant to your symptoms and treatment of your primary complaint

ANY OTHER REASONS FOR RECEIVING TREATMENT

Please summarise any previous or on going treatments or GP referrals for your secondary complaint including appropriate dates and outcomes.

Please indicate any other information that you feel is relevant to your symptoms and treatment of your secondary complaint



Please shade on the diagram the areas where you feel your pain/discomfort

Please mark on the diagram with a cross (x) where you feel areas of numbness or tingling

DENTAL AND JAW ISSUES

Please tell us about any dental and jaw issues which have resulted in surgery, braces, bridges, implants, crowns, difficult extractions and dentures.

Do you wear a jaw splint or mouth guard? yes no

- ❑ Intraoral MFR can be performed to relieve tight jaw and face muscles. Please tick this box if you agree to this treatment

ORTHOTICS

Do you presently wear orthotics? yes no

If so, please tell us about the foot or heel supports that you wear. Please circle as appropriate

Arch support right foot left foot both feet

Heel lift right foot left foot both feet

Fitted by Orthotic specialist or podiatrist? yes no

FEMALES

How many pregnancies have you had?

How many children do you have?

Did you have any difficulty with delivery? If yes what? yes no

Have you had a caesarean section? yes no

Do you consider yourself-

❑ Peri/premenopausal Menopausal Postmenopausal

Do you have any symptoms from the above that bother you?

If you are still having periods, are they periods regular? yes no

CONSENT FOR TREATMENT AND PHYSICAL EXAMINATION

Thank you for providing us with the relevant information on your medical status and your personal details.

Treatment consists of a discussion concerning general medical information and specific information regarding your present complaint after which a physical examination will be carried out. This will include an in-depth assessment of your presenting complaint as well as any other relevant examination procedures. You will be required to change down to your underwear, or if you prefer shorts and a bra top. During treatment you will be draped with sheets or towels.

On subsequent treatments further assessments will be carried out to establish changes to your posture and function and presenting complaint.

Children under the age of 12 will not be treated without a parental or guardian's permission.

❑ Please tick this box if you do not wish us to leave a voicemail or message on your telephone number.

All patient information, medical history, personal details and treatment plans are stored manually which complies with the Data Protection Act.

Payments

Bank Transfers and cash. All treatments will be individually charged. Intensive treatments must be pre-paid.

I understand that charges will apply if I give less than 24 hours notice of any cancellation. I understand that I must inform my therapist if my medical circumstances change at any time.

Signature of client date

Signature of therapist date