**Personal Information Date:**

|  |  |  |
| --- | --- | --- |
| **Name:** | **Phone Number:** | **Gender:** |
| **Email:**  | **D.O.B:** | **Special Population:**  |
| **Occupation:** | **Sports & Hobbies:** | **Age:** |
| **Medication:** | **Previous Medical History:** | **G.P Name & Address:** |

**Client Perception**

|  |
| --- |
| **Reason for Consultation:**  |
| **Client Expectation:** |
| **Problem List:** |
| **Previous Diagnosis:** |
| **Duration & Onset of Symptoms:** |
| **Behaviour of Symptoms:** |

**I confirm the above information is correct and to the best of my knowledge. I consent to continue with a physical examination.**

**Client Signature: Therapist Signature:**

**Contraindication Checklist**

Form must be completed in full Please write yes or no beside the following

***Do you have any of the following conditions? Yes / No***

History of Heart Problems:

Pacemaker:

High Blood Pressure:

Asthma or Other Respiratory Problems:

Epilepsy:

Diabetes:

Any Chronic Illness:

Are You Currently Pregnant?

Are You Post-Natal (3 Months)?

Skin Conditions?

Is There Any Reason you should not receive treatment?

Is There Any Reason You Should Not Exercise?

Which of The Following Best Describes You: (Please Tick)

|  |  |  |  |
| --- | --- | --- | --- |
| **Underweight** | **Normal Weight** | **Over-Weight** | **Obese** |
|  |  |  |  |

***\*\*Please note that best results from our FSM machine are on leaner clients***.

Do You Use Any Mobility Aids: (Please tick)

|  |  |  |
| --- | --- | --- |
| **Walking Stick/Crutches** | **Walking Frame** | **Wheelchair** |
|  |  |  |

**Please rate your pain level before treatment**

1 being little to no pain and 10 being unbearable pain

**1 5 10**

**Please rate your pain after treatment**

**1 5 10**

**Any feedback positive or negative is greatly appreciated, please comment below**

|  |
| --- |
|  |
|  |
|  |

**Signed:­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of appointment: \_\_\_\_\_\_\_\_\_\_\_\_**

