SPORTS & REMEDIAL MASSAGE TREATMENT

Please complete fully using: **CAPITAL LETTERS** **Date:**_______________

Name: ____ D.O.B____________

Address:____

Tel: Number:______________________Email:____________________________

OCCUPATION:

____

G.P NAME & ADDRESS:____

Do you suffer/have from any of the following? (please tick one box):

Question	No	Yes	Action Taken (Practitioner Use Only)
Chest Pain, Palpitations, angina etc?			
Shortness of Breath, asthma etc?			
High or low blood pressure, dizziness?			
Numbness or shooting pain?			
Bowel Problems, Constipation, Diarrhoea etc?			
Skeletal problems, Arthritis, Osteoporosis, Disc Herniation or degeneration, Spondylosis, Spondylitis etc?			
Nausea?			
Problems passing water (urination)?			
Burning sensation on urination?			
Changes in frequency of urination?			
Changes in menstrual cycle?			
Pregnant?			
Menopausal?			
Are you on any prescribed medication?			
Any major illnesses?			
Any major trauma or accidents?			
Any Surgery in the last 2 years?			
Diabetes?			
Varicose Veins?			
Contraceptive implant?			
Any plates, pins or prosthetics?			
Anything else not mentioned?			

EATING HABITS

____

FLUID INTAKE

____

EXERCISE/TYPE x PW

____

PTO

WELL-BEING ____

REASON FOR TREATMENT

____

AREAS OF PAIN
TIGHTNESS/TENSION____

CONTRAINDICATIONS: None Localised to: ________________ Medical Approval Obtained

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Disclaimer

I understand that the Sports and Clinical Remedial Massage that I receive is provided for the basic purpose of relaxation, relief of muscular tension, pain & rehabilitation. If I experience any pain or discomfort during the session, I will immediately inform the therapist and should I fail to do so I understand that there shall be no liability on the therapist's part. I further understand that sports massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as medical advice. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I also understand that the massage therapist reserves the right to refuse to perform massage on anyone whom he deems to have a condition for which massage is contraindicated.
By signing, I am agreeing to the terms above.

Client signature & Date **Therapist signature & Date**
Therapist: Mr Shaun Maddock

*	*
Date:	**Date:**