**Health Screening Form**

*Please complete pages 1-2*

|  |  |
| --- | --- |
| Date of Consultation: |  |

|  |  |
| --- | --- |
| Client Name: |  |
| Date of Birth: |  |
| Gender: | Male  Female  |

|  |  |
| --- | --- |
| Contact Telephone Number |  |
| Address |  |
| Email |  |
| Next of Kin and Contact Details |  |
| GP surgery |  |

Please tell me about your reason for visiting and your ideal outcome from treatment?

|  |
| --- |
|  |

Are you currently experiencing any of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Spinal problems? | Back Pain? | Recent muscle damage? | Severe bruising? | Recent operations? | Pregnancy? |
| Yes  No  | Yes  No  | Yes  No  | Yes  No  | Yes  No  | Yes  No  |
| Recent Fractures or sprains | Swellings | If yes please give details | | | |
| Yes  No  | Yes  No  |

|  |
| --- |
| Do you have any other medical problems, injuries or allergies? |
| Have you previously had treatment for any injuries or significant health problems?  *If yes please give details* |
| Have you had, or are you due to have any investigations for an injury or health problem?  *e.g. X-rays / MRI scans* |
| Do you regularly take, or have been prescribed any medication?  If yes please give details of the medication and reasons for taking it. |
| Exercise History and Lifestyle Information  *(Hobbies, Occupation, Diet)* |

Please tick the following:

I consent to further consultation and treatment

I consent to my information being used to contact me about my appointment

I consent to my information being used to keep me updated about new services, offer and discounts

Signature

Print Name

Date