TENSEGRITY
sports massage

07812 539123
iamsportsmassage@gmail.com
www.tensegrity.me.uk

CONSULTATION FORM

NAME _____ DATE _____

DOB _____ AGE _____ HEIGHT _____ WEIGHT _____

TEL NO _____ EMAIL _____

DOCTOR NAME _____ SURGERY _____

OCCUPATION _____ CURRENT MEDICATION _____

MAIN REASON FOR ATTENDING _____

PLEASE PUT A TICK IN THE BOX IF YOU HAVE ANY OF THE FOLLOWING

HEART DISEASE	❒	EMBOLISM	❒
CIRCULATORY PROBLEMS	❒	VARICOSE VEINS	❒
HIGH BLOOD PRESSURE	❒	DIABETES	❒
LOW BLOOD PRESSURE	❒	EPILEPSY	❒
HIGH CHOLESTEROL	❒	ASTHMA	❒
BLOOD CLOTS/DVT	❒	ALLERGIES	❒
HISTORY OF STROKE	❒	HAEMOPHILIA	❒
OSTEOPOROSIS	❒	CANCER	❒
FRACTURES	❒	SKIN PROBLEMS	❒
JOINT REPLACEMENT	❒	ARTHRITIS	❒
PINS/PLATES	❒	PREGNANT	❒
RECENT ILLNESS	❒	RECENT OPERATIONS	❒
RESPIRATORY PROBLEMS	❒	NEUROLOGICAL PROBLEMS	❒

HOW MUCH TEA/COFFEE DO YOU CONSUME EACH DAY? _____

HOW MUCH WATER DO YOU CONSUME EACH DAY? _____

STRESS LEVEL 1 – 10 _____

IS YOUR DIET GOOD ❒ AVERAGE ❒ POOR ❒

Continued overleaf ...

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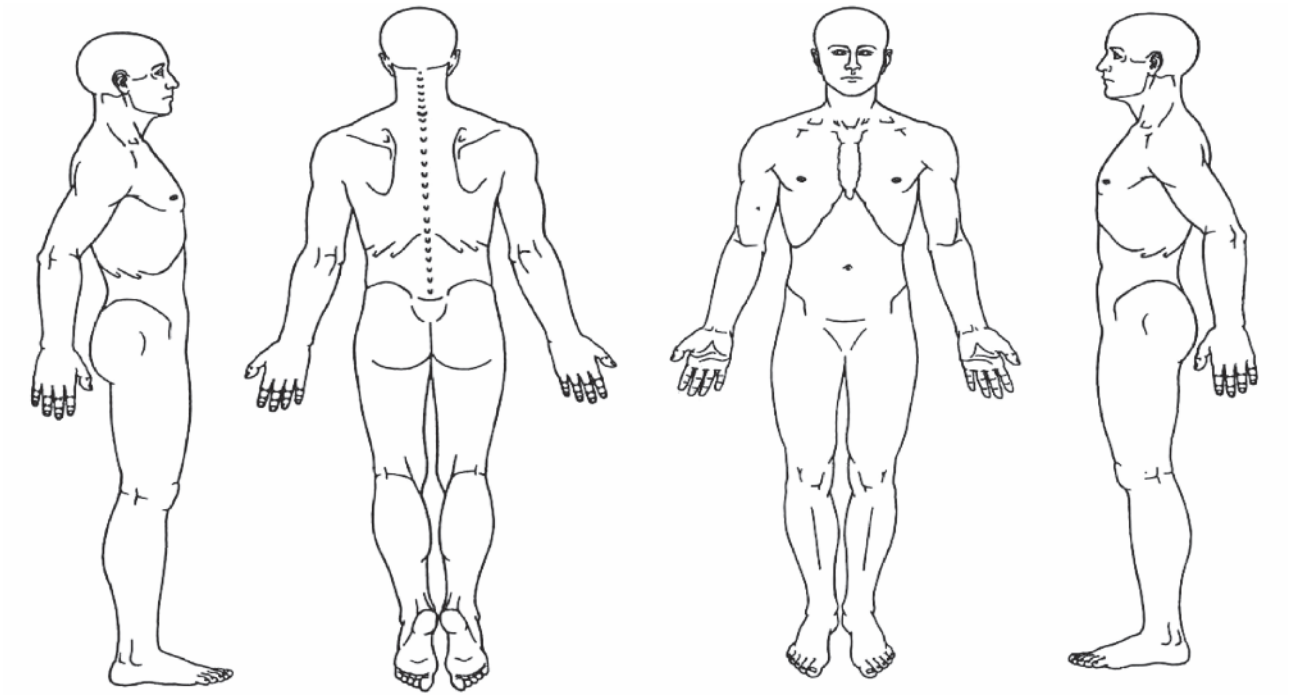
CONSULTATION FORM ... continued

Please circle any areas where you are experiencing pain or discomfort



How long have you had these symptoms? _____

Have you received any previous treatment regarding your symptoms from a doctor, chiropractor, massage therapist, acupuncturist etc?

_____

I confirm that the above information is correct to the best of my knowledge. If there is any change in my condition I will notify my therapist at the earliest opportunity. I understand that this therapy service may involve a combination including physical assessment, sports massage, ultrasound therapy, kinesiology taping and remedial exercises. I understand that all treatment methods will be explained to me, and I give my consent to treatment.

Patient signature _____ Date _____

Therapist signature _____ Date _____