


**eliteperformance sports conditioning**
**Sports Therapy Consultation and Record Form**

Date:

Client name:

DOB:

Age:

Address:

Height (m):

Weight (Kg):

Tel no:

Email\*:

Mobile:

Doctor name:

Surgery:

Tel no:

Occupation:

Exercise routine:

Have you recently visited: doctor/physio/osteo/chiro/pod/other:

Details:

Are you taking any medications?

Main reason for attending this clinic:

Any current problem or history of the following:

Musculoskeletal problems:

Arthritis, osteoporosis, fractures, joint replacement, pins/plates:

Heart/circulatory/arterial/blood pressure:

Thrombosis, embolism, varicose veins:

Diabetes, epilepsy, asthma, allergy:

Skin conditions:

Pregnancies:

Major recent illness:

Any other injury/illness that you feel relevant to the sport therapist:

\* eliteperformance will not share your email address with any third party. We will email following your treatment and also with updates of our services or offers from time to time.

If you do not want to be contacted by email please tick here:

*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 the therapist at the earliest opportunity. I understand that this service may involve a number of techniques and that they will be explained to me and I give my consent to the treatment provided.*

Client name:

Signature:

Date:

Therapist name:

Signature:

Date:

Client name:

Date:

Treatment:

Therapist signature:

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