Mark Diment

MSF MAB Sports Therapist & ITEC DIP

Consultation Form

Surname: _____ Mr/Mrs/Miss/Ms

First Name: _____

Address: _____

Postcode: _____ Occupation: _____

Tel No: _____Email_____

Date Of Birth: _____

Doctors Details: _____ Tel:_____

Do you have or had any of the following:

Rheumatoid arthritis	Any allergies
Fibrosis / muscle discomfort	Whiplash
Cancer or malignant disease	Diabetes
Disc herniated or prolapsed	Headaches / migraines
High / low blood pressure	Broken bones / fractures
Osteoarthritis	Osteoporosis
Spondylitis	Epilepsy
Heart problems	Sciatica

Are you:

Pregnant	YES/NO
Recovering from a recent operation or treatment	YES/NO
Presently taking any medication prescribed by your doctor	YES/NO
Aware of any condition you have which is not mentioned on this form	YES/NO

Patients declaration

I declare that to the best of my knowledge the information I have given is correct. The treatment procedure has been fully explained to me. I am aware that I will be receiving sports therapy treatment incorporating manipulation. I understand that more than one treatment may be necessary and that certain aspects of the treatment may be uncomfortable. I also understand following treatment there may be some discomfort or aching experienced for a few days. All of my questions have been answered and therefore willing to proceed.

Patients signature _____ Date _____