



Client Information and Consent Form

Name: _____

Address: _____

_____ Post Code: _____

Date of Birth: _____ Age: _____

Contact Number(s): _____

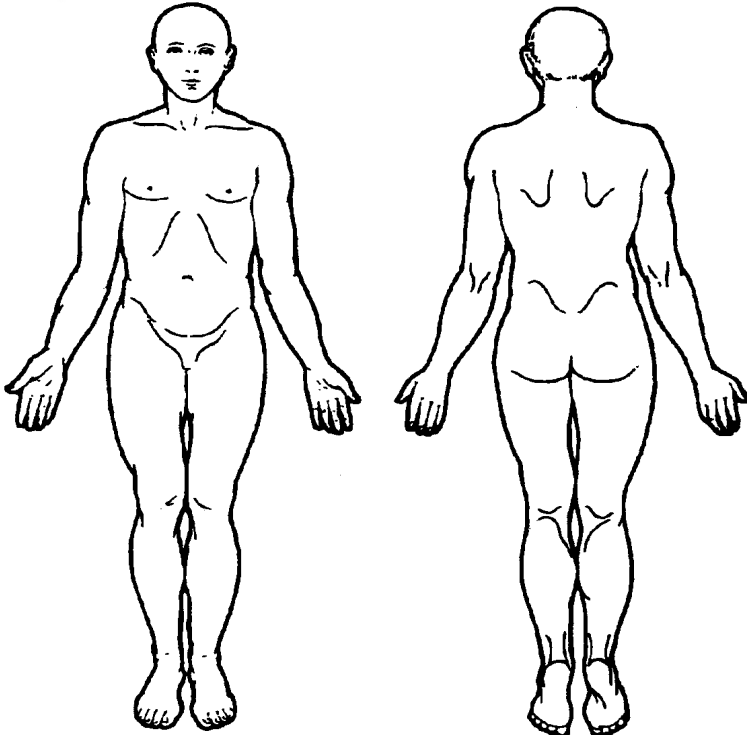
Email Address: _____

Occupation: _____

How did you hear about GTD Sports Therapy?: _____

Exercise routine: _____

What is your major area of concern that you would like to be treated? (write below & circle areas)



On the body diagrams, please circle the areas that you are experiencing problems/pains/stiffness etc.

If you are experiencing pain in one area and feeling it elsewhere, please indicate with arrows.



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Have you recently visited - doctor/consultant/physiotherapist/osteopath/chiropractor/other?

Details: _____

Have you consumed alcohol/recreational drugs in the last 24 hours?

Details: _____

Any major/recent operations or illnesses: _____

Any known allergies: (particularly to metal) _____

Any known Blood Borne Virus: _____

Thrombosis/embolism/varicose veins: _____

Heart Condition: _____

Diabetic: _____

Migraines/headaches: _____

Paralysis/numbness: _____

Fractures/sprains: _____

Joint replacement/pins & plates: _____

Any Joint Injuries: _____

Female Clients only: Are you pregnant? _____

I confirm that the 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 therapy service may involve a combination of techniques including: physical assessment; sports massage; medical acupuncture; joint manipulation therapy; remedial massage; heat and cold application; electro-therapy; ***Kinnective Therapy; Bellabaci Cupping therapy***; remedial exercise. I understand that all treatment methods will be explained to me and I give my consent to the treatment provided.

CANCELLATION POLICY: Failure to cancel a pre-booked appointment will incur the full cost of the session booked and will be payable at the point of attending the next appointment.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____