

30 for 30 Client Details Sheet

Client Details

Name: _____

Date of birth: _____

Address: _____

Contact Phone No: _____ E-mail address: _____

Occupation & Work Description: _____

Hobbies: _____

How did you hear of us: _____

Goals of Treatment:

Please list any injuries to the area to be massaged and treatment received:

Medical History

Please tick those applicable to you. If you currently have a medical condition not on this list, please tick the 'Other' category and provide details

	Yes	No	If yes please give details
• Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Heart Disease / Heart Attack / Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	_____
• High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
• High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you:

Smoke (now or in past) Yes No

Trauma / Accidents

Have you ever been in an accident or experienced significant trauma: Yes No

If yes please give details (dates, injuries received, treatments):

Medications

Are you currently taking medication (prescription, non-prescription, contraceptive pills, pain killers etc)

Yes No

If yes please give details (Name of medication, reason taken, frequency):

Declaration

Are there any other conditions, or medical information that your therapist should be aware of?

Yes No

If yes please give details

I declare that all the information provided is correct, and I have documented any information I feel is relevant to the diagnosis of my presenting problem and to my treatment.

Name: _____ Date: _____