**Consultation and Consent form for Sports Therapy Treatments**

|  |  |
| --- | --- |
| **Client name** :   | **Doctor** : |
| Address: | Address: |
| Telephone: | Telephone: |
| Date of birth: Age:  |
| Occupation: email |

|  |  |
| --- | --- |
| Sports club | **Exercise** : None Regular Trained |
|  |
| **REASON FOR VISIT**:  |

I understand that if certain conditions below are highlighted I should seek medical advice and obtain a doctor’s note if necessary before treatment.

I understand that I must inform the person delivering the treatment of any changes to my medical condition or other relevant conditions.

**PLEASE CIRCLE ANY THAT APPLY**

|  |  |  |
| --- | --- | --- |
| **Total contra-indications** | **GP consent required** | **Local contra-indications** |
| Fever | Pregnancy | Skin conditions |
| Contagious disease | Thrombosis | Varicose veins |
| Drugs | Recent operation | Pregnancy (abdomen) |
| Alcohol | High Blood pressure | Cuts/grazes |
| Cancer | Low blood pressure | Bruising |
| Neuritis inflammation | Medication | Scar tissue |
| Notes: | Heart conditions | Sunburn |
| Covid 19 please complete separate form | Notes: | Menstruation |
|  | Arthritis | Allergies |
|  | Asthma severe | Asthma mild or exercise induced |
|  | Nervous disorder | Notes: |
|  | Epilepsy |  |
|  | Diabetes |  |
|  | Medical oedema |  |

**GP consent required YES NO GP consent obtained YES NO**

Client signature.......................................................... Date ..............................................................

I consent for maintain and train to hold electronic records purely for the purpose of communications and at no point will this information be passed to a third party

Signature ……………………………………………….. Date …………………………………………………..

DATA REGISTRATION ZA334564