**Client Details**

Name:       Date of Birth:

Gender: Male  Female  Height (cm):       Weight (Kg):

Address:

**Contact details**

Phone:       Email: l

**In case of emergency contact**

Name:       Contact Number:       Relationship:

**How did you hear about Muscle Doctor**?

**If any of the following conditions apply to you, please tick the corresponding box:**

Allergies  Headaches/Migraines  Diabetes  Cancer  Arthritis

Joint Replacement  High/Low blood pressure  Neuropathy

Fibromyalgia  Stroke  Heart Attack  Numbness

Deep vein thrombosis  Strains/sprains  Pregnancy  Recent surgery

Open wounds/sores  Undiagnosed lumps  Infection/skin condition  Other

Please tick if there is any reason why the treatment cannot be carried out

If you have ticked any of the above boxes please provide more detail here:

I hereby confirm that the information stated above is accurate and to the best of my knowledge and that thorough and honest responses to these questions are essential to my safety. I will inform my therapist of any changes to the above information.

I understand that an assessment needs to take place I order to establish a treatment plan.

**Client:**

Signed:       Date:

**Therapist:**

Signed:       Date:

Please tick if you would like to be added to the Muscle Doctor Mailing List. You will receive a quarterly newsletter as well as offers and discounts