**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 in order to establish a treatment plan.

**Client:**

Signed:       Date:

**Therapist:**

Signed:       Date:

Please tick if you would prefer not to be added to the Muscle Doctor Mailing List. As a mailing list member, you will receive a quarterly newsletter as well as offers and discounts

**COVID19 Questionnaire**

**Testing**

Have you had a COVID19 test? If yes, when?       Yes  No

If it was a positive result, has the isolation period expired? Yes  No

Do you still have symptoms? Yes  No

**Symptoms –** Are you experiencing any of the following?

Severe breathing difficulties or chest pain Yes  No

Difficulty in waking or confusion Yes  No

*If you have answered yes to any of the above call 999*

Fever Yes  No

Onset, or worsening of cough Yes  No

Sore throat or runny nose Yes  No

Chills or headache Yes  No

Pain swallowing Yes. No

Muscle or joint ache Yes  No

Fatigue or exhaustion Yes  No

Loss of taste or smell Yes  No

*If you have answered yes to any of the above, the advice is to self-isolate for 7 days. A COVID19 test may be necessary - call 119.*

Shortness of breath or difficulty lying down due to chest issues Yes  No

If you have answered yes to the above question, contact your GP or call 111.

Have you been in contact with anyone with COVID19 symptoms? Yes  No

Have you recently been hospitalised? Yes  No

**Are you**

An NHS frontline worker Yes  No

A carer – home or care home? Yes  No

Shielding a vulnerable adult? Yes  No

Pregnant. If yes, how many weeks? Yes  No

Aged over 70 Yes  No

Allergic to latex gloves or specific cleaning products? Yes  No

If you have answered yes to any of the questions above, please provide more details here:

**Signed**

I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue or false, then I am aware I can be prosecuted for making a false declaration.

If either I or someone I have been in contact with tests positive for COVID19 or have been contacted by NHS Track & Trace I will inform you.

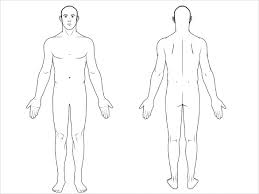
I consent for you to inform NHS Track & Trace if so required.

Signed:

Date:

**Pain form**

Please indicate on the figures below where the issue is:



Further details:

When did you first become aware of it?

Was the pain a sudden or a gradual onset?

How would you describe the pain?

What makes it better?

What makes it worse?

What treatment (if any) have you had regarding this particular complaint?

Have you seen a GP regarding this particular complaint? Yes  No

If yes, please give further details

Are you taking any related medication? Yes  No

If yes, please give further details