**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