**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 like to be added to the Muscle Doctor Mailing List. You will receive a quarterly newsletter as well as offers and discounts [ ]