CLIENT QUESTIONNAIRE

PERSONAL MEDICAL HISTORY

Please print clearly. This questionnaire is important for future reference.
Your information will remain strictly confidential.

SMA
THE ASSOCIATION FOR SOFT TISSUE THERAPISTS

YOUR CONTACT DETAILS

Title Mr/Mrs/Miss/Other : .....
First Name : .....
Surname : .....
Address : .....
.....
.....
Postal Code : .....
Home tel : .....
Work tel : .....
GP's name and address : .....

Mobile : .....
E-mail : .....
Date of birth : .....
Occupation : .....
How did you hear of Sports Massage/me? : .....
(e.g. friend, physio, etc) .....
Contact and phone number in case of emergency :
.....

YOUR MEDICAL HISTORY

Do you or have you suffered from any of the following?

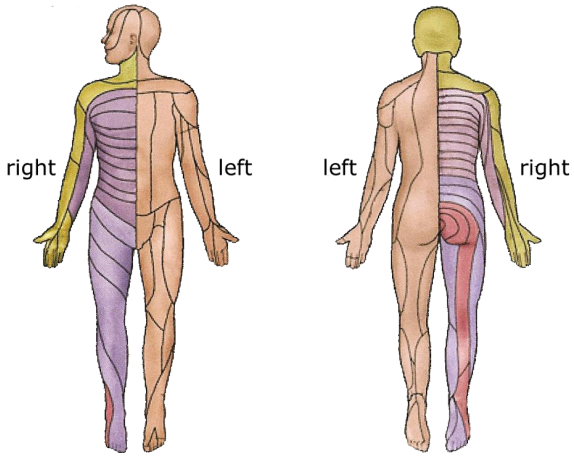
Yes	No	If yes please provide more detail :
☐	☐	**a** Diabetes? Confirm whether IDDM or NIDDM (diet or medication controlled) Are your glucose levels stabilised?
☐	☐	**b** High or low blood pressure (BP)? If high is your BP stabilised by medication. What medication do you take?
☐	☐	**c** Cardiac/Heart problems? If yes have you had an exercise stress test?
☐	☐	**d** Injury (please specify)? Have you been cleared to exercise by your doctor?
☐	☐	**e** Epilepsy? If yes have your seizures been stabilised on medication?
☐	☐	**f** Asthma or other breathing problems? If yes do you require regular medication during exercise?
☐	☐	**g** Osteoporosis?
☐	☐	**h** Digestive complaints? (e.g, ulcers, reflux, collitis)
☐	☐	**I** Any bowel or bladder disfunction? (If yes please provide more detail)
☐	☐	**j** Any recent unexplained weight loss?
☐	☐	**k** Any diagnosis of any form of cancer? If yes where?

Yes	No	Please provide answers to the following questions. Have you :
		NB. Please mark injuries relating to the following questions with an **'X'** on the body chart on the next page as well as answering the following questions
☐	☐	**a** Been involved in a major accident (including motor accidents)? If yes please specify
☐	☐	**b** Had any surgery? Please specify.
☐	☐	**c** Had any bone or stress fracture? Do you have any metal plates, pins or screws in place?
☐	☐	**d** Had any foot or ankle problems or injuries? If yes please specify
☐	☐	**e** Had any knee or hip problems or injuries? If yes please specify
☐	☐	**f** Had any shoulder, elbow or wrist problems or injuries? If yes please specify
☐	☐	**g** Had any other muscle/tendon or ligament problems or injuries? If yes please specify
☐	☐	**h** Suffered any neck problems or injuries (e.g. whiplash)? If yes indicate date
☐	☐	**I** Had any lower back problems or injuries. If yes indicate date of first occurrence and any recurrent episodes
☐	☐	**j** Been diagnosed as hypermobile (excessive joint mobility)?
☐	☐	**k** Been excused work due to pain or disability? If so how long have you been off work?
☐	☐	**l** Is there any other condition or disability not covered above that I should be aware of in treating you as a rehabilitation client? (Activities include bending, stretching, muscle strengthening and breathing exercises)

Please use the remaining page space for any detail you would like to add in respect of previous questions :

YOUR SYMPTOM SPECIFIC HISTORY

Body chart



Do you experience pain or discomfort?

Yes / No If **'no'** please proceed to **Q.9**

If **'yes'** please note the painful areas with a **'P'** on the body chart above and answer :

1 Where is the discomfort? (e.g. in my lower right back or in my left calf)

.....

2 Discomfort has been present since? (if from injury please summarise sport/circumstances)

.....

3 Please place an **'X'** on the following scales to indicate the severity of pain in relation to Q.1

What is your typical or average pain?

0 (no pain) |.....|.....|.....|.....| 10 (worst possible pain)

What is your pain now?

0 (no pain) |.....|.....|.....|.....| 10 (worst possible pain)

4 Are you taking any pain relieving medication now? Yes / No

5 Is the pain : Improving? Unchanging? Worsening?

Is pain worse in : Morning? Afternoon? Evening?

6 What makes your discomfort better (relieving factors)

.....

7 What makes your discomfort worse (aggravating factors)

.....

8 Please summarise any previous treatment(s) and the outcome

.....

9 Please provide the name(s), occupation, tel 'no' of any relevant person currently treating you

Do I have your permission to contact them? Yes / No

.....

10 Please list any other fitness or sports you participate in and indicate how frequently

.....

11 Do you feel that your work contributes to the symptoms? If yes please explain in brief.

.....

ADDITIONAL RELEVANT INFORMATION

Yes	No	
☐	☐	**a** Have you had any recent investigations (e.g. X-ray/MRI scans or blood tests)? What was the result?
☐	☐	**b** Do you have any relevant reports/referrals that can be provided relative to your treatment
☐	☐	**c** Are you taking any medication not already mentioned in this questionnaire?
☐	☐	**d** Is there a history of ill health in your family (e.g. heart disease, cancer, diabetes)? Include parents, grandparents, brothers, sisters.
☐	☐	**e** Do you feel your diet provides you with adequate nutrition?

TERMS, CONDITIONS AND CONSENT TO TREATMENT

I declare that the above information is correct to the best of my knowledge. If there is any change in my reported condition I will notify you at the earliest opportunity.

You have given the name of your GP. Do I have your permission to contact them if necessary? Yes / No

I am aware that I have the right to see my treatment records and that these are confidential and will not be released to any other person without my written consent.

I have been informed that I may be accompanied during any/all treatment.

I understand that payment is due at the end of each visit and that the full fee may be charged for non-attendance or cancellation with less than 24 hours notice

Fees :

First visit/assessment : £

Sessional fees :

1 hour	£
3/4 hour	£
1/2 hour	£

I agree to Sports Massage treatment as deemed necessary after assessment and discussion with : ..... **MSMA (Practitioners name)**

Signed : ..... Date : .....

TREATMENT NOTES

Date :	Notes: