CONSULTATION FORM	**DATE:**

PERSONAL DETAILS

Name:	GP Name & Address:
Address:	Last visit to GP:
Telephone:	No of children (if applicable):
Email:	

Age Group:

☐ Under 20	☐ 30-40	☐ 50-60
☐ 20-30	☐ 40-50	☐ 60+

HEALTH QUESTIONNAIRE

☐ Are you currently on any medications?
details:______________________________

☐ Have you been diagnosed with any of the following:Cardiovasular conditions (thrombosis, phlebis, hypertension, heart conditions)
details:______________________________

☐ Any condition being treated by a GP or health professional, e.g. Physiotherapist, Osteopath, Chiropractor
details:______________________________

☐ Any dysfunction of the nervous system (e.g. Muscular sclerosis, Parkinson's, Lupus, Motor Neurone disease, Fibermyalgia
details:______________________________

☐ Have you experienced any of the following (even old injuries) e.g. ankle/knee/ligament injury
details:______________________________

☐ Have you experienced any of the following in the past 3 months: balance issues, pins & needles, vision blurring, dizziness, shortness of breath?
details:______________________________

☐ Have you had any comprehensive medical tests done to diagnose your condition & Date? e.g. X-ray, CT scan, MRI...
details:______________________________

☐ Which situations increase your pain, discomfort or decreased mobility: sitting, standing, walking, running, stairs, lifting,
overhead reaching, squatting, bending, twisting...
details:______________________________

☐ Are you/ were you involved in any sports, athletics, exercise/training program, physical activity?
details:______________________________

☐ How frequently do you feel pain? e.g. Constantly (more than 75% of time), frequently (50-75% of the time),
occasionally (25-50% of the time), intermittently (0-25% of the time)

☐ Have you had any regular Therapy/Treatment, Pilates or suspension training. if yes, where?
details:______________________________

☐ What is your occupation? What activity does your typical day involve? e.g. Sitting at a computer, lifting…
details:______________________________

☐ What are your goals? What to you want to achieve the most from this program? e.g. strengthen core, correct posture,post-injury rehabilitation, acute pain relief, increase strength & mobility...

☐ Osteoporosis ☐ Arthritis ☐ Nervous/Psychotic conditions ☐ Epilepsy ☐ Diabetes ☐ Asthma ☐ Medical Oedema ☐ Haemophilia ☐ Whiplash ☐ Bell's Palsy ☐ Trapped/Pinched nerve (e.g. sciatica) ☐ Slipped/bulging disc ☐ inflamed nerve ☐ Cancer ☐ Postural deformities (e.g. scoliosis) ☐ Spastic conditions ☐ chronic kidney infections/ UTI's ☐ Undiagnosed pain	☐ Fever ☐ Contagius or infectious diseases ☐ Alcohol or drug addiction ☐ diarrhoea and vomiting ☐ skin diseases ☐ Undiagnosed lumps and bups ☐ Localised swelling/inflammations ☐ Varicose veins ☐ Pregnancy ☐ cuts/buruises/abrasions ☐ Scar tissue ☐ Sunburn ☐ Hormonal implants ☐ Haematoma ☐ Hernia ☐ Recent Fracture/Surgery (6 months) ☐ Cervical spondylitis ☐ Gastric ulcers
If you have answered Yes to any of the above questions, please ensure that it has been diagnosed and treatment has been recommended by a medical practitioner.	**If you have answered yes** to any of the above questions, **written permission is required by GP/ Specialist and attach to the consultation form.** ☐ Consult Form Attached

INFORMED CONSENT DISCLAIMER

Please read carefully and only sign if you are in full agreement with its contents

I ____________________________________ have read and understood the conditions and risks of the treatment/exercise (delete as appropriate) I am about to receive/participate in, and confirm that I am willing to proceed:

☐ without confirmation from my own GP or Consultant

☐ I have consulted with my GP or Consultant and have been given permission to proceed with treatment.

I understand that it is my responsibility and not that of the student/therapist to consult my GP or Consultant.

I hereby indemnify core-moves and it's staff and therapists against any adverse reaction or injury sustained as a result of the treatment/exercise programme I am about to commence.

Client Signature____________________________________ Date________________

Therapist Signature_________________________________ Date________________