Caroline Arnold
Sports Therapy and Pilates Clinic

PATIENT PERSONAL INFORMATION:

Title: ..... Name: .... DOB: .....

Address: ....

..... Post Code: ... . Email: ....

Tel number home: .... Tel number mobile: ....

GP name and address: ....

Occupation: .... Occupational Information: .. ..

....

PERSONAL MEDICAL INFORMATION/FAMILY HISTORY:

>25 units of alcohol?	Yes/No	Major surgery?	Yes/No
Allergies or sensitivities	Yes/No	Menstruation problems	Yes/No
Are you pregnant?	Yes/No	Neuropathy	Yes/No
Asthma or breathing problems?	Yes/No	Osteoarthritis	Yes/No
Back pain (detail episodes)	Yes/No	Osteoporosis	Yes/No
Blood Clots	Yes/No	Other skin conditions	Yes/No
Cramp	Yes/No	Pacemaker	Yes/No
Diabetes	Yes/No	Pelvic pain	Yes/No
Diarrhoea/Constipation	Yes/No	Psoriasis	Yes/No
Eczema	Yes/No	Recently diagnosed with serious disease?	Yes/No
Epilepsy	Yes/No	Rheumatoid Arthritis	Yes/No
Fibromyalgia	Yes/No	Smoker	Yes/No
Fractures	Yes/No	Steel plates/Pins fitted	Yes/No
Headaches/Migraines	Yes/No	Stroke	Yes/No
Heart problems	Yes/No	Suffered any serious injuries?	Yes/No
Heartburn/Indigestion	Yes/No	Swollen Ankles	Yes/No
High or low blood pressure	Yes/No	Thyroid problems	Yes/No
History of any cancer	Yes/No	Urinary problems	Yes/No
Inflammatory Disease – incl IBS/Crohns	Yes/No	Varicose Veins	Yes/No
Joint injuries	Yes/No	Weight gain/loss	Yes/No
Kidney Dysfunction	Yes/No		

Additional health info incl. X-rays/investigations/treatment: ....
....
....
....
....
....

Medication:..... ....
....

General health, sleep, diet, stress, exercise, hobbies:..... ....
....
....

INJURY/CONDITION PRESENTATION:

Injury/condition and mechanism/Single or Multiple sites: ....
....
....
....
....
.... Date of injury: .....
Provocates/Improves condition/Notable pain variants: ....
....
....
....

Pain detail:

Constant/unremitting	Intermittent	At rest	On movement
Burning	Hot	Throbbing	Shooting
Stabbing	Radiating	Stinging	Pins and Needles
Aching	Localised	Multi pain location	

Pain level at point of injury: .... Pain level today: .....

Current/previous treatment:.... ....

....

....

Historical injuries to this region: ....

....

....

Incidents of previous injuries: .. ..

....

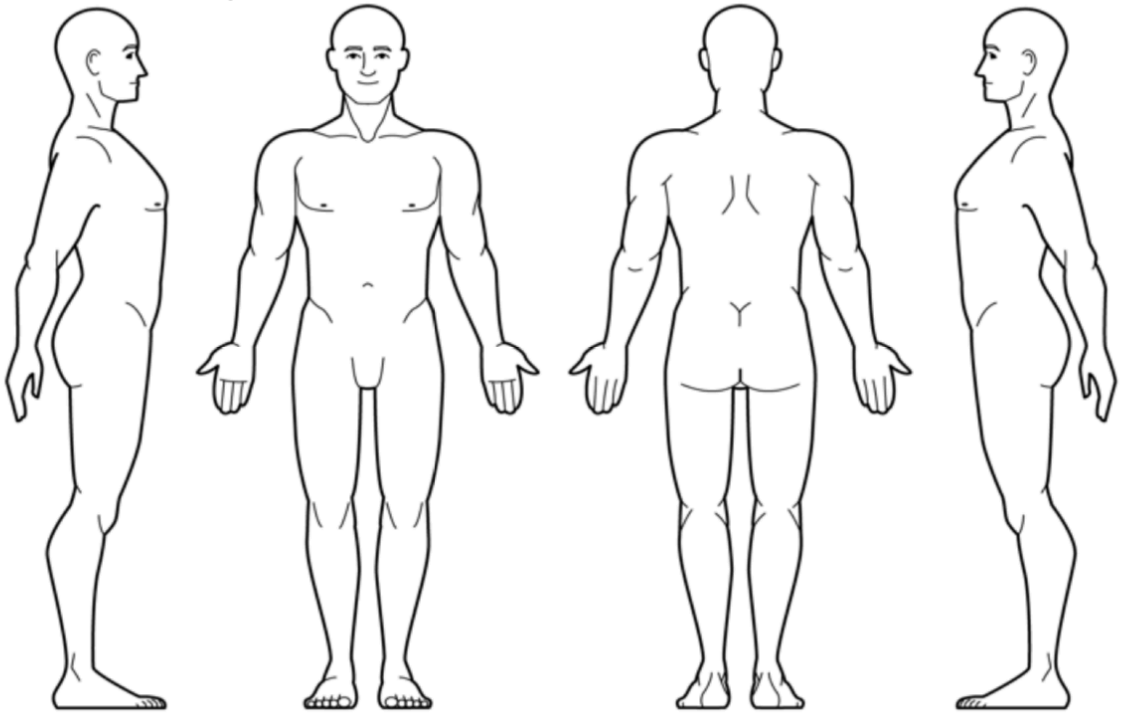
....

Additional patient info: ....

....

....

Please circle any areas of discomfort



DECLARATION AND FEES:

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

The nature of and the reason for personal details, examination and treatment has been fully explained to me by Caroline Arnold. I understand that a level of undressing may be required for the assessment and that this has been fully explained to me. I give my consent to these procedures being used as part of the Examination and Treatment offered. I also give consent for my records to be shared with other health professionals if required on notification by Caroline Arnold.

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

Signed C Arnold: . ... Date: ....