

Sports Massage Consultation Form



Name	Male	Female
Address	Date of Birth	
	Current Medication	
GP Name		
GP Address		

Sport/Position/Event

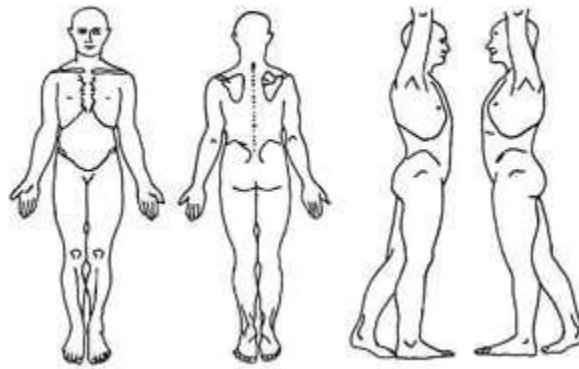
Contraindications

Acute Trauma (72hours)	Y	N	Heart Conditions	Y	N
Haematoma	Y	N	Heart Surgery	Y	N
Sprains/Strains	Y	N	Haemophilia	Y	N
Ruptures	Y	N	Osteoarthritis	Y	N
Fractures	Y	N	HIV/AIDs	Y	N
Open Wounds	Y	N	Sensory Deficiency	Y	N
Hypertension	Y	N	Varicose Veins	Y	N
Angina	Y	N	Bursitis	Y	N
Infections	Y	N	Skin Conditions	Y	N
Rheumatoid Arthritis	Y	N	Diabetes	Y	N
Myositis Ossificans	Y	N	Epilepsy	Y	N
Pregnant	Y	N	Allergies	Y	N
Gout	Y	N	Hypotension	Y	N

If yes to any of the above, please give further details:

Does this patient require a GP Referral? Y N

Reason for Clinic visit:



Assessment Information

I consent to receiving a sports massage. The treatment has been explained to me and I have had the opportunity to ask questions. All the information provided is true to the best of my knowledge and I will not hold the university responsible for any undisclosed medical condition or ailment that may contraindicate me from treatment. I understand that the therapist is still training under the University of Wales Trinity Saint David and that they will be supervised at all times during treatment. I am aware that my treatment records will be kept confidential and secure and that I can request a copy of them (in writing) at any time.

Client Signature: _____ Date: _____.

Therapist Signature: _____ Date: _____.

Date:	Treatment Given	Aftercare Advice Given	Feedback	Name of Therapist