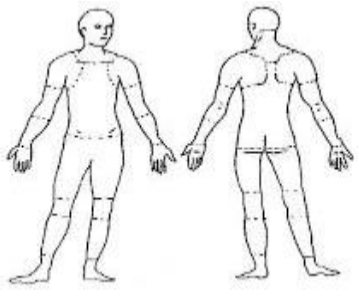
MarieCartwright.com
Sports Therapy

Marie Cartwright – Consultation Form Date:

Name		
Profession		
DOB		I am: Male ☐ Female ☐
Phone		**Email**:
GP Name & Surgery		
Have you had or do you have any of the following ☐ **Yes** ☐ **No**	☐ Heart condition ☐ High Blood Pressure ☐ Diabetes ☐ High Cholesterol ☐ Pregnancy	☐ Any Allergies ☐ Skin Condition ☐ Epilepsy ☐ Cancer or remission ☐ Bad Back
	☐ Asthma or any Lung condition ☐ Kidney condition ☐ Osteoporosis or weak bones ☐ Stress Related Issues ☐ Any Other Medical condition	
If you answered YES to any of the above, **Operations** (inc. cosmetic surgery) ☐ **Yes** ☐ **No**	Please provide details of the condition: Please list any medication taken: Please provide details:	
Injuries – Current & Past ☐ **Yes** ☐ **No**	Please provide details of injury, injury dates, recovery, rehabilitation etc:	
Sport/s or Physical Activity practiced **Sporting Event**, Which?	Please list and provide details of training frequency:	
Painful/ Injured Areas – Please Circle	Front View Back View  Neck/Back/ Shoulder L R/ Arms L R/ Wrist L R/ Fingers/ Chest/ Abs/ Hip L R/ Groin L R/ Front Leg L R/ Back Leg L R/ Knee L R/ Calf L R/ Ankle L R/ Foot L R (**Please Circle**) Other pain (please specify)	

I confirm that all given information is true and complete to the best of my knowledge and I will inform of any change in circumstances. I have been informed of the treatment I will receive, I give my consent and take full responsibility of any reactions I may have. *Please note that you also confirm to give 24hr notice for any cancellations and late arrivals for which you may incur a charging fee.*

Your Signature **Date**