Patient Medical Information Form

Please fill in all relevant information. However feel free to leave anything out if you wish to discuss it personally with your therapist prior to your appointment.

Name:		**Date of birth:**		**Age:**	

Address:						
Telephone:	**Home:**		**Work:**		**Mobile:**	
Email:						
Occupation:						

GP's Name and Address:	

You MUST complete this part of the form so we can process your claim.

Who is paying your for your treatment?	Yourself ☐	Private health Insurer ☐ *It is important that you fill in your insurance details below*

Insurance Company: **E.g.: BUPA etc.**			
Policy Number:		**Authorisation Number:**	
Claim Number:			

Height:		**Weight:**		☐ **Right** / ☐ **Left Footed**	☐ **Right** / ☐ **Left Handed**

Smoke:	☐	**Drink:**	☐	**Sport and Frequency:**	

Medical History (*please tick*)*

- ☐ Any surgery within last 5 years
- ☐ Allergies (including massage oils)
- ☐ Epilepsy
- ☐ Any metal pins or plates as a result of surgery
- ☐ Any Hernias known
- ☐ Any circulatory problems, Thrombosis etc
- ☐ Major Illness / injury
- ☐ Liver / Kidney ailments
- ☐ Skin Diseases / disorders
- ☐ Pregnant
- ☐ Gout
- ☐ Are you currently taking any form of medication (including Homeopathic remedies)

Please give further details of you have ticked any of the above:

Do you suffer from any of the following: (please tick)*

- ☐ Back pains
- ☐ Nervous disorders
- ☐ Thread veins
- ☐ Blood born diseases (Hep B, AIDS, HIV)
- ☐ Varicose veins
- ☐ Broken capillaries
- ☐ Reduced reflexes (if known)

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Please give further details of you have ticked any of the above:

Please give details of past injury history:

Please give details of current injury history: (This will be very helpful for us)

I agree to the treatment by my therapist, which may include massage, exercise, manipulation and electro-medical techniques and confirm that the above information is correct to the best of my knowledge. I have discussed and agreed my treatment plan and I also am aware that I am responsible to pay for my account and if using private medical insurance, I am responsible for any shortfall with my account.

To complete at your consultation

Patients signature:		**Date:**	
Therapists signature:		**Ref number:**	

Data Protection
Pulse Sports Therapy is registered under the data protection act and no information will pass on to any 3rd party whatsoever. The information is kept strictly confidential and used only in conjunction with the treatment that you are receiving.