LH PRO FITNESS

# Client Record

## Personal Details

*Surname (Mr/Mrs/Miss/Ms) .....

*First name .....

*Date of birth .....

*Gender ☐ M ☐ F *Height ..... *Weight .....

*Address .....

*Home telephone .....

Work telephone .....

*Mobile .....

*Email .....

## Lifestyle Details

Occupation .....

*Hobbies/Interests .....

*Physically related activities .....

## Doctor's Details

*Name .....

*Contact number .....

*Address .....

## Medical History

**Do you have, or have you had any of the following symptoms/conditions in the past 6 months? Please tick all boxes that apply.**

| | | | |
|---|---|---|---|
| Skin disorders | ☐ | Cancer | ☐ |
| Myositis | ☐ | Cardiovascular disease | ☐ |
| Recent operations | ☐ | Diabetes (if not fully controlled) | ☐ |
| Inflammation | ☐ | Epilepsy | ☐ |
| Sprains and strains | ☐ | Disorders of the nervous system | ☐ |
| Cuts and bruises | ☐ | Disorders of the lymphatic system | ☐ |
| Fractures | ☐ | Auto immune disorders | ☐ |
| Phlebitis | ☐ | HIV and AIDS | ☐ |
| Bursitis | ☐ | Severe hypertension/ hypotension (if not fully controlled) | ☐ |

| | | | |
|---|---|---|---|
| Varicose veins | ☐ | Thrombosis (DVT) | ☐ |
| Burns | ☐ | Neural disorders | ☐ |
| Airborne infections | ☐ | Pneumonia | ☐ |
| General fever | ☐ | Substance abuse | ☐ |
| Glandular fever | ☐ | Cancer | ☐ |
| Undiagnosed lumps | ☐ | Cardiovascular disease | ☐ |
| Unstable pregnancy | ☐ | Diabetes (if not fully controlled) | ☐ |
| Medically weak skin, bone, tissues | ☐ | Severe hypertension/ hypotension (if client controlled) | ☐ |
| Haemophilia | ☐ | Asthma | ☐ |
| Pregnancy | ☐ | Allergies | ☐ |
| Undiagnosed musculo-skeletal disorders | ☐ | Headaches | ☐ |
| Menstruation | ☐ | Sinusitis | ☐ |
| Diabetes (if client controlled) | ☐ | | |

**Please provide details where applicable.**

| | | |
|---|---|---|
| *If required, has permission been given by the GP/Consultant to carry out the treatment? (please attach letter) | Yes ☐ | No ☐ |
| *Have you visited your GP in the last 6 months? *If yes, give details.* | Yes ☐ | No ☐ |
| *Are you on any prescribed medication? *If yes, give details.* | Yes ☐ | No ☐ |
| *Are you receiving treatment from another healthcare professional? *If yes, give details.* | Yes ☐ | No ☐ |
| *Do you suffer from any allergies? *If yes, give details.* | Yes ☐ | No ☐ |

**I hereby confirm that the information stated above is accurate to the best of my ability. I further fully understand that thorough and honest responses to these questions are essential to my safety. I undertake to inform my therapist of any changes to the above information.**

*Signature .....

*Print name .....

*Date .....

**I understand that an assessment needs to take place in order to establish a treatment plan. All assessment and treatment procedures have been thoroughly explained and I am happy to proceed.**

*Signature .....

*Print name .....

*Date .....

| | |
|---|---|
| | ..... |
| Therapist Signature | ..... |
| Print name | ..... |
| Date | ..... |