TRIUMPH FITNESS
Your body is our challenge

CLIENT RECORD

Client Details

Mr/Mrs/Miss/Ms……..Surname……..First name……
D.O.B……..M/F……..Height……..Weight……
Address……
Contact numbers : Day ……..Eve……Mobile……**EMAIL**……

In case of emergency contact
Name……Contact number……..Relationship……

Client lifestyle Details

Occupation……Full time /Part time……
Hobbies.interests/activities……
Physically related work activities……

GP Details

Name……..Contact number……
Surgery address……

Medical History

Do you have , or have you had in the past 6 months, any of the following symptoms/ conditions?

Observable contraindications	y/n	GP contraindications	y/n	Precautionary conditions	y/n
skin disorders myositis recent operations inflammations sprains and strains cuts and bruises fractures phlebitis bursitis varicose veins burns airborne infections general fever glandular fever undiagnosed lump unstable pregnancy		Cancer Cardiovascular disease Epilepsy Diabetes(if not fully controlled) Disorders of the lymphatic system Disorders of the nervous systems Auto immune disorders HIV and AIDS Severe hypertension/ hypotension(if not fully controlled thrombosis (DVT) neural disorders pneumonia substance abuse		Medically week skin, bones, tissues Hemophilia Pregnancy Undiagnosed musculo-skeletal disorders Menstruation Diabetes(if client controlled) Severe hypertension/ hypotension(if client controlled) Asthma Allergies Headaches sinusitis	

Details……
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If required, has permission been given by the GP/Consultant to carry out the treatment ? (please attach letter) y/n……

Have you visited your GP in the last 6 months? y/n Details……

Are you on any prescribed medications? y/n Details……

Are you receiving treatment from another healthcare professional? y/n Details……

Do you suffer from any allergies? y/n Details……

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

Signed……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.

Signed……Date……

Therapist Signature……Date……

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