MYO SPORTS® THERAPY

Consultation Form

Name:

Address:

Tel No: (home) (Mobile/work)

Email: Date of Birth:

Occupation:

GP'S Name:

Address:

Sports Played:

Have you ever had a major operation? YES/NO
IF SO PLEASE GIVE DETAILS:

Are you currently taking any medication? YES/NO
IF SO PLEASE GIVE DETAILS

Do you or have you ever suffered from any of the conditions below?

EPILEPSY		HEART CONDITION		SKIN CONDITION	
ASTHMA		JOINT PROBLEMS		BLADDER PROBLEMS	
DIABETES		SPINAL FRACTURES		OSTEOPOROSIS	
MIGRANES		OTHER FRACTURES		CANCER	
		OTHER ILLNESSES			

Are you pregnant, have you been pregnant or had a baby within the last 6 months? YES / NO

Any other condition you feel we should know about?
IF SO PLEASE GIVE DETAILS

Where did you hear about MYO SPORTS THERAPY _____

By signing this form, I agree to pay half the session fee should I cancel my appointment with less than 24hrs notice.

IF YOU ARE HAPPY THAT ALL THE INFORMATION ABOVE IS CORRECT PLEASE SIGN AND DATE BELOW, THANK YOU FOR YOUR CO-OPERATION.

SIGNED: DATE: