Date Consultation was Completed:

Date of Treatment:

Thank you for your interest in Deep Tissue/Sports Massage. Your responses to this questionnaire will help to ensure that we are aware of any special considerations or medical conditions that we need to know for your safety and comfort. Please answer all questions with as much detail as you can and **return the completed form to Viki** by the day before your treatment

1. Personal Details & Medical

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | D.O.B: | |  | Male: |  | Female: |  |
| e-mail: |  | | | | Occupation: | |  | |
| Contact/Mobile No: |  | | How did you find Rejuvenate? | | | |  | |
| Occupational Duties:  Describe your activity on an average day: | | |  | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have a history of, or are currently suffering with any of the following conditions: | | | |
| Diabetes (Type I or Type II) or Diagnosed Pre- Diabetic |  | High/Low Blood Pressure |  |
| Epilepsy |  | Deep Vein Thrombosis (DVT) |  |
| Cancer/Tumours |  | Osteoporosis |  |
| Arthritis |  | Skin Conditions |  |
| Pregnancy |  | Other |  |
| If you have answered yes to any questions above or have any other medical concerns, please give details: | |  | |
| Please list any medications you are taking or have used in the past 6 months: | |  | |

1. **Lifestyle – Home and Work**

|  |  |
| --- | --- |
| Please detail all exercise and sport undertaken over and above your daily routine.  *E.g. gym work, cycling, running, Yoga, Pilates, football, martial arts, weight training.*  Include all activity, frequency per week, distance travelled, reps/sets completed, weight lifted, hours dedicated to exercise and everything relevant to your routine.  Also include the amount of rest you have between exercise sessions or training and where this falls in your average active week. |  |
| Please give details of any recent changes in your exercise/sporting routine.These include things such as training surface, changes in training clothing or equipment, any increase /decrease in activity and whatever else you feel is of interest to your consultation and treatment plan. |  |
| Please detail all activity not included in daily routine or counts as exercise/sport. E.g. Dog-walking, long periods of walking, standing, heavy lifting. |  |
| How long do you spend:  Driving, working from a desk, on a computer, sitting watching T.V, playing video games?  Please specify for each one. |  |
| Has your desk at work, should you have one, been risk assessed?  Ideally, your desk should be at the level of your bellybutton, all equipment including keyboards and monitors should be directly in front you; monitors should be at eye level. Is this the case?  Please give details of the current setup of your workspace. |  |

1. **Injury/Illness History**

|  |  |
| --- | --- |
| Have you ever suffered from any breaks, fractures, ligament sprains, muscle strains, whiplash or impact collisions of any kind?  Please list all relevant and specify what, when, where, how, which side and any after-effects you have experienced. |  |
| Are there any illnesses or conditions within your family that you feel I should be aware of?  E.g. Arthritis, bone disorders, cancers, strokes, heart attacks.  Please specify all relevant details, as far back as grandparents is sufficient, but as far back as parents is fine if you are unsure. |  |

1. **Current Complaint or Reason for Treatment**

|  |  |
| --- | --- |
| Please give details of any current complaints you are suffering from. Please include left or right side (or both!), location, all affected structures (e.g. knee, shoulder, neck, lower back, hip, elbow) |  |
| Describe the pain/ sensation  *e.g. sharp, stabbing, radiating, local to one area, dull, achey*  and rate it on a scale of 1 (no pain) to 10 (the most painful thing ever!)  Specify a difference in pain at different times of day (if there is one), if there is a certain movement or activity that makes it worse/better, does it keep you awake at night?  Does exercise make the pain ease or intensify? |  |
| Are you experiencing any tingling, loss of sensation (total or partial) or burning in or around any of the affected areas?  When do you experience these sensations?  Give details of when the problem started, at what time of day it can be more or less painful, whether the pain comes and goes, and how long between these periods. |  |
| Can you think of a specific trigger that caused the problem(s) in the recent weeks/months? If so, please give as much detail below as possible. |  |

1. **The Treatment**

|  |  |
| --- | --- |
| Please state which massage base would you prefer for your treatment  *Perfume & fragrance-free base oil, massage cream or talc?*  ***Please state the purpose for treatment: Injury, to relax, overuse through training etc.*** |  |
| Are there any other factors that you feel have not been covered by the previous questions?  Please feel free to write anything else you feel is relevant or would be of interest to me regarding your treatment. |  |

If you are unsure of any question, please do not hesitate to email me [**viki.drury@yahoo.co.uk**](mailto:viki.drury@yahoo.co.uk) or call/text on **07921286758**

Again, thank you for your time and effort in completing this form. I look forward to seeing you very soon.

Regards,

**Viki Drury**

**Bsc (Hons) Sports Therapist**