TRAMORE PHYSIOTHERAPY PRACTICE

Date								
Paid								

Name: _____ Age: _____

Address: _____

Telephone No: _____ Hobbies: _____

Occupation: _____ _____

_____ Dominance: _R / L Handed

Medical Complaints: Do you suffer from the following: (please √ yes / × no)

Blood Pressure	☐	Diabetes	☐	Heart Condition	☐
Lung Problem	☐	Psychiatric Problem	☐	On Disability	☐
Allergies	☐	Osteoporosis	☐		

Medications: Please List _____

_____

Have you ever taken Steroids: _____

Name of GP / Consultant: _____

Have you had any Surgery in the past / If so Please List: _____

_____

Have you had Previous Complaints: _____

Current Complaint:

- Did you have an Injury? _____
- Date of Onset: _____
- Brief history of what happened: _____

_____

X-Ray _____ MRI _____ Other _____

Have you had Physiotherapy before: _____

How did you hear of Tramore Physiotherapy: Friend / Colleague / Doctor / Club / Other

I Consent to Physiotherapy Signed _____ Client

Physiotherapist _____ Date _____

_____

_____

_____