# Private Client Details Sheet

**Personal Details**
Mr / Mrs / Miss / Ms / Dr

Surname ____________ Given ___________________

Email address _________________________________

Postal _______________________________________

_________________________ P/C________________

Ph (H) _________________ (M) ___________________

Date of Birth ______________________

Occupation __________________________________

Physical Activities _____________________________

Family Doctor ________________________________

Closest Relative _______________________________

Ph (H) ________________ (M) __________________

We have a regular e-newsletter with lifestyle and injury prevention tips. All clients receive this, please tick if you wish to op out ☐

**Referral Details**
How did you come to attend our centre?
☐ Doctor _________________________ (name)
☐ Previous Client
☐ Friend/Family __________________________
☐ Yellow Pages ☐Local Directory ☐ Newspaper
☐ Talk/Seminar ☐ Walk by ☐ Hospital
☐ Internet ☐ Other__________________________

**Pension Details**
Type ______________
Number ____________________

**Private Health Insurance Details**
Name __________________
Number ___________________

**Medications**

__________________________________________________
__________________________________________________
__________________________________________________
__________________________________________________
______________________________________________

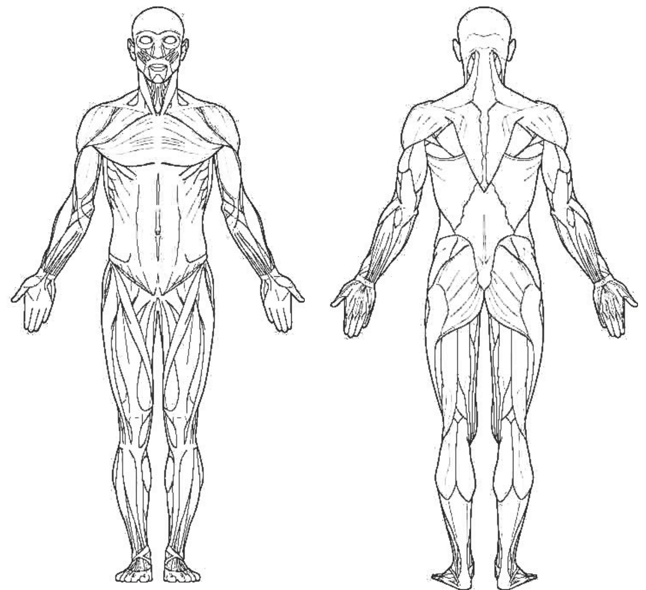
**Update Date** ________ Sig ________ Witness _________

**Update Date** ________ Sig ________ Witness _________

**Do you have or use any of the following?**

| | |
|---|---|
| High Blood Pressure | Yes ☐ |
| Fit Faint or Funny Turn | Yes ☐ |
| Epilepsy (last seizure ____ /_____ /_____) | Yes ☐ |
| Panic Attacks | Yes ☐ |
| Tumour history | Yes ☐ |
| Asthma | Yes ☐ |
| Allergy to metals | Yes ☐ |
| Diabetes | Yes ☐ |
| Bleeding disorder | Yes ☐ |
| Tuberculosis | Yes ☐ |
| Hepatitis A, B, C, HIV/AIDS | Yes ☐ |
| Pacemaker or other implants | Yes ☐ |
| Heart Valve Replacement | Yes ☐ |
| Autoimmune Diseases | Yes ☐ |
| Mastectomy | Yes ☐ |
| Are you pregnant | Yes ☐ |
| Use Corticosteroids | Past ☐ Current ☐ |

**Pain Map/Description**



Please shade your area(s) of pain.

In past 24 hours please grade your;

- Current pain 0 1 2 3 4 5 6 7 8 9 10
- Worse pain 0 1 2 3 4 5 6 7 8 9 10
- Least pain 0 1 2 3 4 5 6 7 8 9 10