

Patient Name:

Address:

DOB:

Doctor’s name and surgery:

Have you had a formal diagnosis for your condition?

If yes, by whom and what is your diagnosis?

If no, please list your symptoms:

How long have you had the complaint for?

Did it start for any reason?

Has it worsened since it started?

Do any of the following apply – if YES please state which:

Cardiac pacemaker, metal or plastic implants, cancer, malignancy, infection, deep vein thrombosis, haematoma, peripheral vascular disease, bleeding disorder, recent steroid injection?

Is there anything in your medical history that our therapist should be aware of?

Are you taking any medication? If yes, please list below.