CLIENT RECORD CARD

SURNAME……FORNAME……

ADDRESS……

TELEPHONE……D.O.B……

General Health – Please answer Yes or No

Any Operations, Illnesses or injuries in last 6 months?

Any History of major Operations or Illnesses?

Any known Disorder or Condition?

Are you currently receiving any form of medication or Treatment

Allergies – please list:

…….
By signing the following you are confirming that your medical information is up to date, that you have received the treatment logged and were given clear aftercare advice.

DATE	TREATMENT	NOTES	CLIENT SIGNTURE	THERAPIST NAME