PERFORMANCE TRAINING ACADEMY

SMT Client Assessment Form

Client Record

Client Details		
(Mr/Mrs/Miss/Ms)	Surname:	First Name:
D.O.B:	Height:	Weight:
Address:		
Tel no:	Email:	
In case of emergency contact:		
Name:	Tel no:	Relationship:

Client Lifestyle Details		
Occupation:		Hours per week:
Hobbies/Interests/ Activities:		
Physically related work activities:		
GP Details		
Name:	Tel no:	Surgery:

Medical History					
Do you have, or have you had in the past 6 months, any of the following symptoms/conditions?					
Observable contraindications	y/n	GP contraindications	y/n	Precautionary conditions	y/n
• Skin disorders • Myositis • Recent operations • Inflammation • Sprains and strains • Cuts and bruises • Fractures • Phlebitis • Bursitis • Varicose veins • Burns • Airborne infections • General fever • Glandular fever • Undiagnosed lumps • Unstable pregnancy		•Cancer •Cardiovascular disease •Diabetes •Epilepsy •Disorders of the nervous system •Disorders of the lymphatic system •Auto immune disorders •HIV and AIDS •Severe hypertension/ hypotension •Thrombosis (DVT) •Neural disorders •Pneumonia •Substance abuse		• Medically weak skin, bone or tissues • Haemophilia • Pregnancy • Undiagnosed musculo-skeletal disorders • Menstruation • Diabetes (controlled) • Severe hypertension/ hypotension (controlled) • Asthma • Allergies • Headaches • Sinusitis	

Details/notes: _____

_____

_____

If required, has permission been given by the GP/Consultant to carry out the treatment? (Please attach letter) y/n

Have you visited your GP in the last 6 months? y n Details_____

Are you on any prescribed medication? y n Details _____

Are you receiving treatment from another healthcare professional? y n Details _____

Do you suffer from any allergies, especially nut? y n Details _____

I hereby confirm that the information stated in this form is accurate to the best of my ability. I further fully understand that thorough and honest responses to these questions are essential to my safety. I undertake to inform my therapist of any changes to the above information.

Signed: _____Print: _____

Date: _____

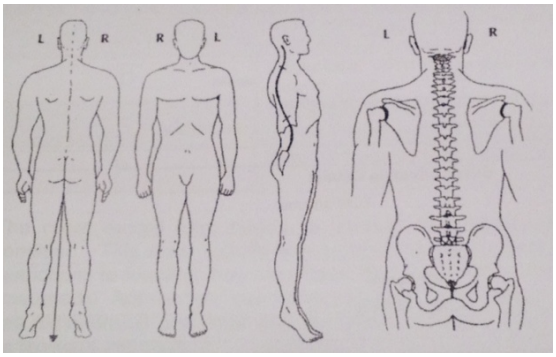
I understand that an assessment needs to take place in order to establish a treatment plan. All assessment and treatment procedures have been thoroughly explained and I am happy to proceed.

Signed: _____Date: _____

Therapist Signature: _____Date: _____

Examination

Present complaint



General observation: _____

_____

_____

Ranges of Movement

Joint	Movement	Active	Pain	Passive	Pain	Resisted	Pain

Special Tests	Positive	Negative	Comments

Therapist Signature: _____ Date: _____

Soft Tissue Symptoms

Symptom	Action	Symptom	Action

Treatments

Therapist Signature: _____ Date: _____