Consultation Form

Pilates Klinik - Joondalup

Personal Details

Name: Michael Abbott Address: Tapping

Phone: (Home)_____(Mobile): 0408282540 Email:_____

Date of Birth: _____ Do you know the time of your birth? ____ Location: _____

Occupation:_____ Hobbies: _____

Next of Kin/Emergency Contact (Full Name): _____ Phone/Email: _____

Health Details:

Initial Reason for Treatment (relaxation, sports injury, muscle soreness etc.):_____

Medication in use (for example, steroids, HRT etc.):_anti depressant_____

Are you Pregnant? N/A or Y/N Due Date_____

Health Conditions/Symptoms – please tick

High/low blood pressure		Diabetes		Other conditions (Please specify)	
Cancer		Epilepsy		Hx currently experiencing	
Respiratory conditions		Contagious skin conditions		flared up herniated	
Heart Conditions		Recent Pregnancy		disc (Hx 7 years ago)	
High Cholesterol		Varicose Veins			
Thyroid		Allergies			
Thrombosis/Phlebitis		Poor Circulation			
Digestive problems		Kidney/bladder			
Stress	✓	Arthritis/rheumatism			
Emotional Problems		Menstruation Problems			
Depression	✓	Infertility			
Insomnia		Hormonal Problems			
Migraine/Headaches		Fluid Retention			
Backache		Cellulite			
Other Conditions		Overweight			

Lifestyle/Diet – please circle Y/N and describe details, if possible.

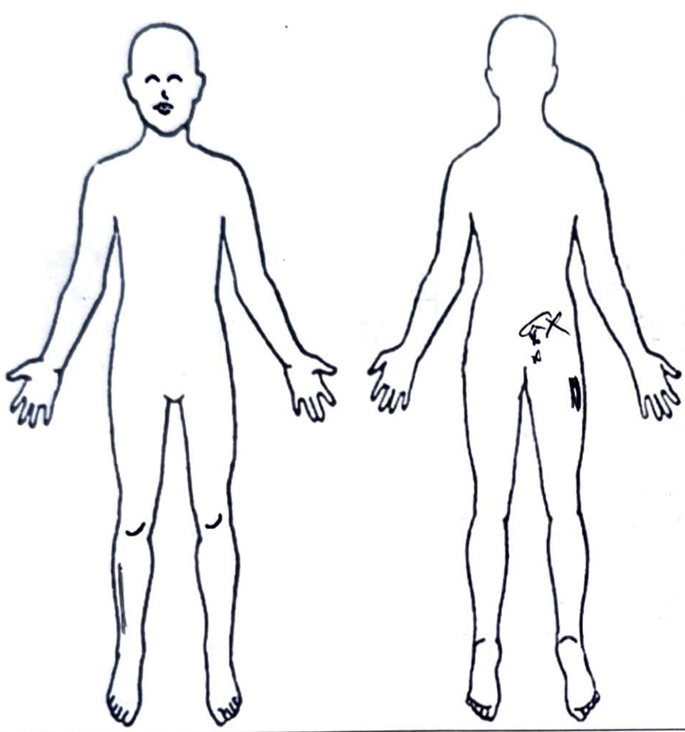
Smoking Y/(N) – how often?		PAST 12HRS (if applicable)	
Exercise (Y)/N – how often?		Fever	Y/(N)
Alcohol (Y)/N – how often		Diarrhoea	Y/(N)
Water (Y)/N – how much per day?		Vomiting	Y/(N)
Tea Y/(N) how much per day?		Contagious Illness	Y/(N)
Coffee Y/(N) – how much per day?		Under influence drugs/alcohol	Y/(N)
Vegetarian/Vegan Y/(N)		Others not mentioned	

Formal Consent

I understand that the services received today, Massage Therapy, Beauty Therapy, I receive is provided for the basic purpose of relaxation, stress reduction and muscular tension and most important pure enjoyment. I further understand that the massage, skin treatment, and any other aspects relating to today's treatment should not be construed as substitute for medical examination, diagnosis, or treatment in any manner. The treatments performed today do not take the place of medical treatment where needed. If you are in doubt, please consult your doctor or physician.

Date: 20/ 6 / 20 Name: M. Abbott Signature: _____

Physical Assessment (Office ONLY)



Main Observations(Office ONLY)

- Hx Herniated disk 7 years ago
- Refered pain (R) peroneal side
- SLR + inversion (Peroneal n. stretch (+) on (R).

Consultation Form – Notes (Office ONLY)

Name: ~~Mat~~ Michael Abhot **Address:** ______________________________

9-(6)-20 – PB massage – calfs & glutes very (+) (bi); Lx not on (+) shoulders + N (+) on (L). Suggested self traction + side self mobilisation & Lx ext exercises to support w/ the pain.