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| **Please complete in BLOCK CAPITALS** |
| **Title and Forenames(s):**  | **Surname:** |
| **Address:** (Parents’ address if student) |
| **Postcode:** | **Date of Birth:** |
| **Email address:** (students and staff: provide university email address) | **Phone Number:** (for appointment text reminders) |
| **Job title/nature of work:** | **Or subject of study:** |
| **What sport/exercise do you participate in?** |
| **GP Names and Address:** |
| **Injury Information:** Please provide a brief description of your injury and any background information that might help. |
| **Relationship to the University of Bristol. Are you: *[Please tick ✔️]*** |
| Current student: 🞎 | Current staff member: 🞎 | Alumni: 🞎 | Member of public: 🞎 |
| **Do you have a** [**University of Bristol sport membership**](https://bristol.ac.uk/sport/memberships/) **(“Active pass”)? *[Please tick✔️]*** |
| Student: 🞎 | Staff: 🞎 | Affiliate: 🞎 | Public: 🞎 |
| **Payment details: *[Please tick ✔️]*** |
| Self-Funding (to be paid online): 🞎 | Health Insurance (provide details below): 🞎 | Occupational Health referral: 🞎 |
| **Select Insurer: *[Please tick ✔️]*** |
| **AXA PPP** 🞎 | **BUPA** 🞎 | **OTHER** 🞎 Please provide Insurer name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*[We will provide detailed receipts to enable you to reclaim from your Insurer direct]* |
| **Authorisation Number:** | **Membership Number:** |
| **Excess amount:** | **Number of treatments covered:** |
| **PLEASE COMPLETE PAGE 2** |



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| **Medical History Questionnaire** |
| To obtain the best and safest treatment, please complete the following questions: |
| ***All answers treated with the strictest of confidence.*** | **No**  | **Yes** | **Details** |
| Have you attended this clinic before? |  |  |  |
| Are you currently receiving treatment from a doctor or healthcare professional? |  |  |  |
| Do you smoke? |  |  |  |
| Are you taking any medication? |  |  |  |
| Do you have any allergies?  |  |  |  |
| Have you ever had a serious illness? |  |  |  |
| Have you ever had an accident/injury requiring medical attention? |  |  |  |
| Have you ever had an operation? |  |  |  |
| Do you have high blood pressure? |  |  |  |
| Do you have any heart problems? |  |  |  |
| Do you have any lung/breathing problems? |  |  |  |
| Do you have any kidney or liver disease? |  |  |  |
| Do you suffer from epilepsy? |  |  |  |
| Are you diabetic? |  |  |  |
| Have you been diagnosed with osteoporosis? |  |  |  |
| Have you had any adverse or unexpected reactions to previous physiotherapy, osteopathy, acupuncture or massage? |  |  |  |
| Do you have any skin problems? |  |  |  |
| Do you have a bleeding disorder? |  |  |  |
| Do you have any family history of bone/joint disorders? |  |  |  |
| Is there anything else we should know about your health? |  |  |  |
| Are you, or could you be, pregnant? |  |  |  |
| Have you ever had problems with infrequent or irregular periods? |  |  |  |
| **Consent** | ✔️ |
| I consent to assessment and delivery of treatment recommended and performed by the therapist, in accordance with the relevant professional bodies' guidelines. I understand that a full explanation of the treatment purpose and risks will be given and I must inform the therapist of any concerns or questions immediately. I understand I can withdraw my consent to participate in treatment at any time. In signing this form I agree to these conditions. | 🞎 |
| **Declaration** | ✔️ |
| I understand that I am liable for any payment not covered by my health insurance. | 🞎 |
| I agree to contact the Sports Medicine Clinic to cancel my appointment 24 hours in advance otherwise a £20 cancellation fee will be added to my account. | 🞎 |
| I understand that non-attendance will result in the full appointment fee being due | 🞎 |
| **Signed:** | **Date:** |
| **THERAPIST USE ONLY** |
| **DATE** | **INITIALS** | **ASS/DIS** | **DATE** | **INITIALS** | **ASS/DIS** | **DATE** | **INITIALS** | **ASS/DIS** | **DATE** | **INITIALS** | **ASS/DIS** |
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