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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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