



Barnes Sports Clinic

Case History Form

50 Box Road, Bathford, Bath, BA1 7QH ♦ 01225 859047 ♦ info@barnessportsclinic.co.uk

Name: _____ Date: _____

Address: _____ Telephone number: _____

_____ Email: _____

Postcode: _____ Occupation: _____

G.P.'s name: _____ Date of Birth: ____ / ____ / ____

Surgery: _____ Are you: Male

Female

Problem(s) or injuries: _____

Approx. duration of problem/injury: _____

Have you had:
X Ray: Yes No MRI Scan: Yes No

Symptoms of problem/injury: _____

How problem/injury occurred: _____

Do you smoke? Yes No If yes, how many per day? _____

How many units of alcohol do you consume each week? (approx.) _____ units.

What sports/leisure activities do you participate in? _____

Please list any medication you are currently taking: _____

Please list any allergies you are known to have: _____

Do you have any of the following conditions? (Please circle if applicable)

Heart condition	Yes	No	Pregnancy	Yes	No
Circulatory condition	Yes	No	Screws/Plates	Yes	No
Digestive disorders	Yes	No	Bronchitis	Yes	No
Asthma	Yes	No	Hysterectomy	Yes	No
Tumours/Growths	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	High/low blood pressure	Yes	No
Epilepsy/Fits	Yes	No	Rheumatic or Osteo-Arthritic condition	Yes	No

I confirm that the information above has been given to the best of my knowledge and I undertake treatment/rehabilitation in the clinic/gym at Barnes Sports Clinic at my own risk.

Sign: _____ Print name: _____ Date: _____