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| **Please indicate if you have any of the following conditions:** |
|  | Yes | No | Details: |
| High blood pressure | Y | N | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Osteoporosis | Y | N | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cancer or previous cancers | Y | N | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Joint replacements | Y | N | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Fitted pins or plates | Y | N | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Unexplained weight loss | Y | N | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Name: Date of Birth:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Number:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address (in block capitals):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact & Number:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As part of your agreement in booking your appointment, you agree that we may use your data to contact you regarding your appointments. You also agree to having read and understood both the Privacy Policy and the Terms and Conditions as displayed in the waiting room.

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| **Body Chart****24-hour behavior****Red flags/ Contraindications / T H R E A D S**General HealthScansCauda Equina SxVBI SxAllergies  | **HPC:** **Improving Static Worsening** |
| **PMH:****Medications:** |
| **Easing factors:** | **Social and family history:** |
| **Aggravating factors and functional limitations:** | **Severe (low/mod/severe):** **Irritability (low/mod/high):**  |
| **Informed Consent**My Therapist has fully explained their advised treatment plan for my condition. I understand the course of therapeutic and remedial actions which will be undertaken, and hereby give informed consent for treatment. I am aware that the MSH Clinic operates as an educational environment, and as such my treatment plan may be delivered by a student Therapist under supervision. I also consent to my case history being discussed in an educational setting where appropriate.**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Observation** | **Passive** |
| **Resisted**  |
| **Palpation** | **Muscle Control (Lx/Cx)** |
|  | **Accessory Movements** |
| **Active** | **Functional Tests** |
| **Special Tests/Neurological Tests/ U.M.N.L. tests** |

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| **Clinical Impression:** |
| **Treatment Plan:** |
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| **Plan for next session:** |
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