GERARD NOLAN
PHYSIOWORKS

FOCUSED TREATMENT
FOR FOCUSED INDIVIDUALS

www.gnphysioworks.com

This questionnaire is for your safety and our information. The information is strictly confidential

FULL NAME

FULL ADDRESS | POSTCODE

TELEPHONE W: | H: | Mobile:

EMAIL

DATE OF BIRTH (DD/MM/YY)

OCCUPATION

COMPANY

NAME OF GP

GP ADDRESS

CONSULTANT

HEALTH INSURANCE COMPANY
(IF APPROPRIATE)

POLICY NO | GROUP NO/AUTHORISATION

HOW DID YOU HEAR OF US?

MEDICAL CHECK LIST

Have you had any of the following? If yes, please tick

- [ ] Heart conditions
- [ ] Epilepsy
- [ ] Pacemaker
- [ ] Osteoporosis
- [ ] Diabetes
- [ ] Cancer
- [ ] Headaches
- [ ] Car Accident
- [ ] Anti Coagulant Therapy
- [ ] Rheumatoid Arthritis
- [ ] HRT
- [ ] Fractures
- [ ] Gynaecological Problems
- [ ] Operations
- [ ] High blood pressure
- [ ] Bladder problems
- [ ] Long Term steroids
- [ ] Circulation problems
- [ ] Dizziness
- [ ] Asthma

What drugs are you presently taking?

As your comfort and safety is our priority please do not hesitate to tell us if you feel uncomfortable during the treatment or have any questions

I understand that I am responsible for the cost of my treatment. Should I fail to attend a treatment without giving 4 hours prior notice then I am liable for a cancellation fee.
I consent to treatment by the physiotherapist in attendance.

Signature: ______________________ **Date:** ______________________