SCENAR Therapy

Personal Details

Patient Name		Gender	
Address	______________________________ ______________________________ ______________________________		
Postcode			
Tel No. (Daytime)			
Tel No. (Mobile)			
Date of Birth	_ _ / _ _ / _ _ _ _	Age	
Client Reference			

Medical History

Doctor's Name	
Surgery	
Address	______________________________ ______________________________ ______________________________
Postcode	
Tel No. (Daytime)	

Do you have or have you ever suffered with any of the following:

	Yes / No		Yes / No
High/Low blood pressure		Kidney Infection	
Heart condition		Thrombosis	
Varicose veins / phlebitis		Haemorrhage	
Injury / operation		Skin diseases / disorders	
Slipped disc / back condition		Epilepsy	
Rheumatoid / Osteo arthritis		Diabetes	
Abdominal / digestive discomfort		Asthma	
Potentially fatal or terminal condition (cancer, tumour)		Dysfunction of the nervous system (brain tumour, multiple sclerosis)	

Do you have scar tissue / bruises / open cuts / large moles?

Medication

Are you currently having any medication or alternative treatment?

Female clients only:

Is it possible that you may be pregnant? (If Yes, history, inc. miscarriages)

Are you currently menstruating? (Yes / No)

FOR THERAPIST USE ONLY:
Note: Absolute contra-indication for SCENAR treatment patient with a pacemaker.

Initial Diagnosis / Pain Syndrome (localisation):

What are your complaints generally?

What are your complaints at the moment?

Please localise the area: top/bottom; front/back; left right

Mobility range affected:

Pain assessment score:

1 Min	2	3	4	5	6	7	8	9	10 Max

Other notes:

Client declaration:

I declare that I have been informed about SCNEAR treatment (the guidelines, contra-indications and limitations) and I have decided to undertake the treatment willingly and knowingly. I accept that no promise of any cure or curative effect has been given and may not necessarily occur. I am willing to proceed:

Patient's signature

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Therapist signature

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