Name: _____ DOB _____ M / F

Address: _____

City _____ Post Code _____ Phone _____

Mobile _____ Email _____

Occupation / Retired _____

Activities/Exercise _____ Hobbies/Interests _____

_____

Medical contact details _____ Phone _____

Medical history _____

_____

Cancer history: Type _____ Date of Diagnosis _____

Treatment history _____

_____

_____

_____

Medications _____

_____

_____

Current signs and symptoms _____

_____

_____

Treatment goals _____

_____

Session notes _____

_____

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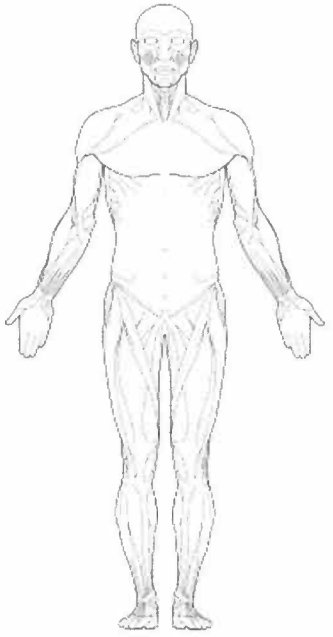
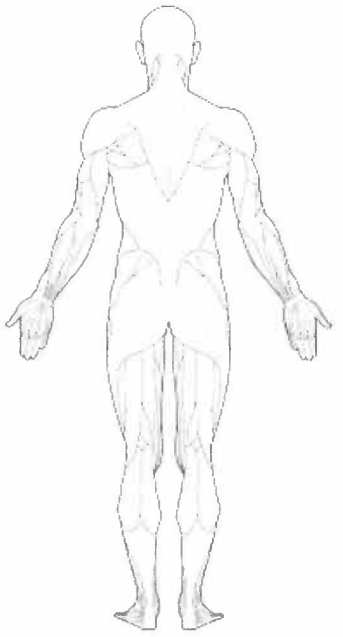
_____

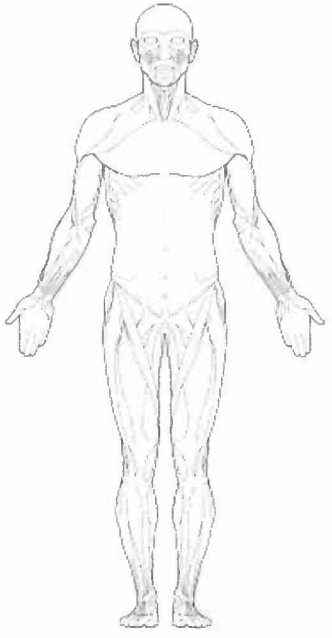
Anterior



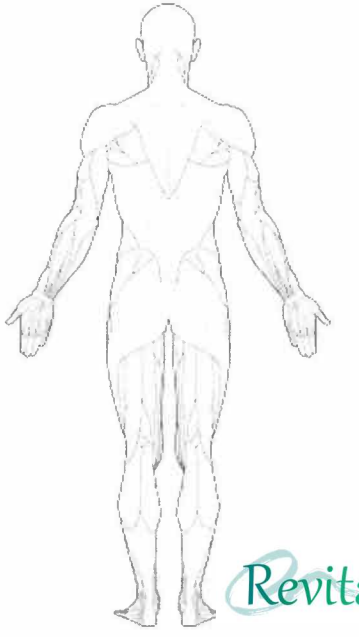
Posterior



Anterior



Posterior



Revitalise
By Katie Reid