Client Consultation Form

**Therapist Details**

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| **Course:** | AROMATHERAPY MASSAGE |
| **Centre name:** | BRIGHTON SCHOOL OF MASSAGE |
| **Learner (Therapist) name:** |  |

**Client Consultation Form**

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| **Client name/code** |  |
| **Address** |  |
| **Profession** |  |
| **Telephone Number** | Mobile |  |
| Other |  |
| **Emergency Contact** | Name |  |
| Contact number |  |
| **Date of initial consultation** |  |

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| Personal details: |
| Age group | Under 18 🞏 | 18 – 29 🞏 | 30 – 39 🞏 | 40 – 49 🞏 | 50 – 59 🞏 | 60+ 🞏 |
| Gender |  |
| GP Surgery and Address |  |
| Last visit to the doctor |  |

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| Contra-indications requiring medical permission *where medical permission cannot be obtained, clients must give their informed consent in writing prior to treatment* *(Select if/where appropriate)* None 🞏 |
| Currently being treated by a GP or another complementary practitioner for any condition? 🞏Notes: |
| Taking prescribed medication? 🞏  |
| Pregnant? 🞏 How many weeks? \_\_\_\_ If first trimester (0 – 12 weeks) massage is contraindicated due to risk of miscarriage. (2nd/3rd trimester (gentle massage, abdomen avoided) |
| Recent operations? Major 🞏 Minor 🞏 Date: \_\_\_\_\_\_\_ Notes: |
| Has a hormonal implant? 🞏 |
| Any dysfunction of the nervous system? (e.g. multiple sclerosis, Parkinson’s disease, motor neurone disease) 🞏 |
| Any skeletal/muscular conditions? (e.g. cervical spondylitis, osteoporosis, arthritis, whiplash, slipped disc)🞏 |
| Any conditions causing muscular spasticity? (e.g. cerebral palsy) 🞏  |
| Any cardiovascular conditions? (e.g. thrombosis, phlebitis, hypertension, hypotension, heart conditions) 🞏  |
| Any mental health / psychotic conditions? 🞏  |
| Any undiagnosed pain? 🞏 Notes: |
| Any of the following conditions:  |  | Asthma  | 🞏 | Diabetes  | 🞏 |
| Epilepsy  | 🞏 | Kidney infection  | 🞏 | Cancer  | 🞏 |
| Haemophilia  | 🞏 | Bell’s palsy  | 🞏 | Medical oedema  | 🞏 |
| Trapped/pinched nerve (e.g. sciatica)  | 🞏 | Inflamed nerve  | 🞏 | Rheumatoid arthritis  | 🞏 |
| Contra-indications that restrict treatment *(Select if/where appropriate)* None 🞏 |
| Fever | 🞏 | Contagious or infectious diseases | 🞏 | Diarrhoea and vomiting  | 🞏 |
| Under the influence of alcohol or recreational drugs | 🞏 | Undiagnosed lumps and bumps | 🞏 | Recent heavy meal (<2hr) | 🞏 |
| Cuts / Bruises / Abrasions | 🞏 | Sunburn | 🞏 | Hypersensitive skin | 🞏 |
| Scar tissue (avoid area - 2 years for major operation; 6 months for a small scar) | 🞏 | Localised swelling | 🞏 | Varicose veins | 🞏 |
| Skin diseases | 🞏 | Hernia | 🞏 | Gastric ulcers | 🞏 |
| Haematoma | 🞏 | Inflammation | 🞏 | Recent fractures (minimum 3 months) | 🞏 |
| Any allergies?  | 🞏 | Menstruating (first few days of menstruation, avoid abdomen) | 🞏 |
| Written permission required by: *(attached to the consultation form)* |
| GP/Specialist | 🞏 | Informed consent | 🞏 |

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| Medical History |
| Reason for treatment |  |
| Muscular/Skeletal problems | Back 🞏 Aches/pain 🞏 Stiff joints 🞏 Headaches 🞏Notes: |
| Digestive problems | Constipation 🞏 Bloating 🞏 Liver/gall bladder 🞏 Stomach 🞏Notes: |
| Circulation | Heart 🞏 Blood pressure 🞏 Fluid retention 🞏 Tired Legs 🞏 Varicose veins 🞏 Cellulite 🞏 Kidney problems 🞏 Cold hands and feet 🞏 Notes: |
| Gynaecological | Irregular periods 🞏 P.M.T 🞏 Menopause 🞏 H.R.T. 🞏 Pill 🞏 Coil 🞏Notes: |
| Nervous system | Migraine 🞏 Tension 🞏 Stress 🞏 Depression 🞏Notes: |
| Respiratory | Allergies 🞏 Hay fever 🞏 Asthma 🞏Notes: |
| Skin | Dermatitis 🞏 Acne 🞏 Eczema 🞏 Psoriasis 🞏 Skin cancer 🞏Notes: |
| Skin type | Dry 🞏 Oily 🞏 Combination 🞏 Sensitive 🞏 Dehydrated 🞏Notes: |
| Immune system | Prone to infections 🞏 Colds 🞏 Sore throats 🞏 Chest 🞏 Sinus issues 🞏Notes: |
| Medication taken |  |
| Herbal remedies |  |
| General health notes |  |
| **Lifestyle** |
| Do you have children? | Yes 🞏 No 🞏  |
| Ability to relax | GoodModeratePoor | 🞏🞏🞏 | Methods of relaxation: |
| Sleep patterns | GoodModeratePoor | 🞏🞏🞏 | Average no. of hours: |
| Natural daylight (e.g.in workplace) | YesNo | 🞏🞏 | Work environment: |
| Work at a computer? | YesNo | 🞏🞏 | If yes, for how many hours? |
| Do you smoke? | YesNo | 🞏🞏 | No. per day: |
| Do you drink alcohol? | YesNo | 🞏🞏 | Units per week: |
| Do you exercise? | NoneOccasionalIrregularRegular | 🞏🞏🞏🞏 | Type/s of exercise: |
| Stress level *(1-10 rating)* | At work At home | \_\_\_\_\_\_ | Notes: |
| Reasons for stress |  |
| **Diet** |
| Do you eat regular meals? | BreakfastLunchDinner | 🞏🞏🞏 |  |
| Do you eat in a hurry? | YesNo | 🞏🞏 |  |
| Do you take any food/vitamin supplements? | YesNo | 🞏🞏 |  |
| How many portions of each of these items does your diet contain per day? | Fresh fruit | Fresh vegetables | Protein | Protein - source? |
| Dairy produce | Sweet things  | Added salt | Added sugar |
| How many units of these drinks do you consume per day? | Tea  | Coffee  | Fruit juice  |
| Water | Soft drinks  | Other |
| Do you suffer from food / other allergies? | YesNo | 🞏🞏 | Details: |
| Do you experience disordered eating? | Bingeing OvereatingUndereating | 🞏🞏🞏 | Notes: |
| **Consultation Notes** |
| Client profile |  |
| Additional notes |  |
| **Treatment Planning** |
| Treatment date and location |  |
| Treatment plan |  |
| Contraindicated oils / oils to avoid *include reason* |  |
| Condition/s to treat and suitable essential oils | Condition: Suitable essential oils: |
| Condition: Suitable essential oils: |
| Condition: Suitable essential oils: |
| Essential oils selected | Oil:Rationale: |
| Oil:Rationale: |
| Oil:Rationale: |
| Carrier oil/s selected | Oil:Rationale: |
| Oil:Rationale: |
| Possible alternative oils |  |
| Blend ratio*include specific amounts of each essential and carrier oil used* | Body:  |
| Face:  |
| **Client signature***To be signed before treatment.* | Please sign here to agree with, and consent to, the proposed treatment plan and oil blend.Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Treatment Notes** |
| Details of how treatment was conducted |  |
| Details of how the client felt during and after the treatment |  |
| Notes on aromatherapy blend |  |
| Specific aftercare and home care advice given*Include any recommended follow up treatment* |  |
| Reflective practice |  |
| **Therapist Signature**  | Please sign here to confirm information is correct.Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |