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** |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 | | Good  Moderate  Poor | | 🞏🞏🞏 | Methods of relaxation: | | | | |
| Sleep patterns | | Good  Moderate  Poor | | 🞏🞏🞏 | Average no. of hours: | | | | |
| Natural daylight (e.g.in workplace) | | Yes  No | | 🞏🞏 | Work environment: | | | | |
| Work at a computer? | | Yes  No | | 🞏🞏 | If yes, for how many hours? | | | | |
| Do you smoke? | | Yes  No | | 🞏🞏 | No. per day: | | | | |
| Do you drink alcohol? | | Yes  No | | 🞏🞏 | Units per week: | | | | |
| Do you exercise? | | None  Occasional  Irregular  Regular | | 🞏🞏🞏  🞏 | Type/s of exercise: | | | | |
| Stress level *(1-10 rating)* | | At work  At home | \_\_\_  \_\_\_ | | Notes: | | | | |
| Reasons for stress | |  | | | | | | | |
| **Diet** | | | | | | | | | |
| Do you eat regular meals? | | Breakfast  Lunch  Dinner | | 🞏🞏🞏 |  | | | | |
| Do you eat in a hurry? | | Yes  No | | 🞏🞏 |  | | | | |
| Do you take any food/vitamin supplements? | | Yes  No | | 🞏🞏 |  | | | | |
| 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? | | Yes  No | | 🞏🞏 | Details: | | | | |
| Do you experience disordered eating? | | Bingeing  Overeating  Undereating | | 🞏🞏🞏 | 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |