

## Client Consultation Form

### Therapist Details

<b>Course:</b>	INDIAN HEAD MASSAGE
<b>Centre name:</b>	BRIGHTON SCHOOL OF MASSAGE
<b>Learner (Therapist) name:</b>	Joanna Sherman

### Client Consultation Form

<b>Client name/code</b>	T.M	
<b>Address</b>	Details held on file.	
<b>Profession</b>	IT Consultancy	
<b>Telephone Number</b>	Mobile	Details held on file.
	Other	Details held on file.
<b>Emergency Contact</b>	Name	Valerie Sherman
	Contact number	Details held on file.
<b>Date of initial consultation</b>	05 / 11 / 2020	

Personal details:						
Age group	Under 18 <input type="checkbox"/>	18 – 29 <input type="checkbox"/>	30 – 39 <input type="checkbox"/>	40 – 49 <input checked="" type="checkbox"/>	50 – 59 <input type="checkbox"/>	60+ <input type="checkbox"/>
Gender	Male					
GP Surgery and Address	Details held on file.					
Last visit to the doctor	September					

**BRIGHTON SCHOOL OF MASSAGE – CLIENT CONSULTATION FORM**

**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. (2<sup>nd</sup>/3<sup>rd</sup> 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 <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Kidney infection <input type="checkbox"/>	Cancer <input type="checkbox"/>
Haemophilia <input type="checkbox"/>	Bell’s palsy <input type="checkbox"/>	Medical oedema <input type="checkbox"/>
Trapped/pinched nerve (e.g. sciatica) <input type="checkbox"/>	Inflamed nerve <input type="checkbox"/>	Rheumatoid arthritis <input type="checkbox"/>

**Contra-indications that restrict treatment** *(Select if/where appropriate)* **None**

Fever <input type="checkbox"/>	Contagious or infectious diseases <input type="checkbox"/>	Diarrhoea and vomiting <input type="checkbox"/>
Recent heavy meal (<2hr) <input type="checkbox"/>	Under the influence of alcohol or recreational drugs <input type="checkbox"/>	Undiagnosed lumps and bumps <input type="checkbox"/>
Cuts / Bruises / Abrasions <input type="checkbox"/>	Sunburn <input type="checkbox"/>	Hypersensitive skin <input type="checkbox"/>
Scar tissue (avoid area - 2 years for major operation; 6 months for a small scar) <input type="checkbox"/>	Localised swelling <input type="checkbox"/>	Varicose veins <input type="checkbox"/>
Skin diseases <input type="checkbox"/>	Hernia <input type="checkbox"/>	Gastric ulcers <input type="checkbox"/>
Haematoma <input type="checkbox"/>	Inflammation <input type="checkbox"/>	Recent fractures (minimum 3 months) <input type="checkbox"/>
Any allergies? <input type="checkbox"/>		Menstruating (first few days of menstruation, avoid abdomen) <input type="checkbox"/>

**Written permission required by:** *(attached to the consultation form)*

GP/Specialist <input type="checkbox"/>	Informed consent <input checked="" type="checkbox"/>
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**BRIGHTON SCHOOL OF MASSAGE – CLIENT CONSULTATION FORM**

<b>Medical History</b>							
Reason for treatment	To help alleviate back and neck pain due to poor posture and frequent headaches.						
Muscular/Skeletal problems	Back <input checked="" type="checkbox"/> Aches/pain <input checked="" type="checkbox"/> Stiff joints <input type="checkbox"/> Headaches <input checked="" type="checkbox"/> Notes: Very tall. Suffers kyphosis through bad posture -> back & neck pain; daily headaches						
Digestive problems	Constipation <input type="checkbox"/> Bloating <input checked="" type="checkbox"/> Liver/gall bladder <input type="checkbox"/> Stomach <input type="checkbox"/> Notes: Client occasionally suffers bloating						
Circulation	Heart <input type="checkbox"/> Blood pressure <input checked="" type="checkbox"/> Fluid retention <input type="checkbox"/> Tired Legs <input type="checkbox"/> Varicose veins <input type="checkbox"/> Cellulite <input type="checkbox"/> Kidney problems <input type="checkbox"/> Cold hands and feet <input type="checkbox"/> Notes: Borderline low blood pressure at 110/80						
Gynaecological	Irregular periods <input type="checkbox"/> P.M.T <input type="checkbox"/> Menopause <input type="checkbox"/> H.R.T. <input type="checkbox"/> Pill <input type="checkbox"/> Coil <input type="checkbox"/> Notes:						
Nervous system	Migraine <input type="checkbox"/> Tension <input type="checkbox"/> Stress <input checked="" type="checkbox"/> Depression <input checked="" type="checkbox"/> Notes:						
Respiratory	Allergies <input type="checkbox"/> Hay fever <input type="checkbox"/> Asthma <input type="checkbox"/> Notes:						
Skin	Dermatitis <input type="checkbox"/> Acne <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Skin cancer <input type="checkbox"/> Notes: Client suffers mild eczema on her hands occasionally						
Skin type	Dry <input type="checkbox"/> Oily <input type="checkbox"/> Combination <input checked="" type="checkbox"/> Sensitive <input type="checkbox"/> Dehydrated <input type="checkbox"/> Notes:						
Immune system	Prone to infections <input type="checkbox"/> Colds <input type="checkbox"/> Sore throats <input type="checkbox"/> Chest <input type="checkbox"/> Sinus issues <input type="checkbox"/> Notes:						
Regular medication taken	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
Herbal remedies taken	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
General health notes	TM is not experiencing any contra indications that require medical permission but has kyphosis						
<b>Lifestyle</b>							
Do you have children?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
Ability to relax	<table border="0"> <tr> <td>Good <input checked="" type="checkbox"/></td> <td rowspan="3">Methods of relaxation:</td> </tr> <tr> <td>Moderate <input type="checkbox"/></td> </tr> <tr> <td>Poor <input type="checkbox"/></td> </tr> </table>	Good <input checked="" type="checkbox"/>	Methods of relaxation:	Moderate <input type="checkbox"/>	Poor <input type="checkbox"/>		
Good <input checked="" type="checkbox"/>	Methods of relaxation:						
Moderate <input type="checkbox"/>							
Poor <input type="checkbox"/>							
Sleep patterns	<table border="0"> <tr> <td>Good <input checked="" type="checkbox"/></td> <td>Average no. of hours: 8 hours</td> </tr> <tr> <td>Moderate <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Poor <input type="checkbox"/></td> <td></td> </tr> </table>	Good <input checked="" type="checkbox"/>	Average no. of hours: 8 hours	Moderate <input type="checkbox"/>		Poor <input type="checkbox"/>	
Good <input checked="" type="checkbox"/>	Average no. of hours: 8 hours						
Moderate <input type="checkbox"/>							
Poor <input type="checkbox"/>							
Natural daylight (e.g.in workplace)	<table border="0"> <tr> <td>Yes <input type="checkbox"/></td> <td rowspan="2">Work environment: basement office</td> </tr> <tr> <td>No <input checked="" type="checkbox"/></td> </tr> </table>	Yes <input type="checkbox"/>	Work environment: basement office	No <input checked="" type="checkbox"/>			
Yes <input type="checkbox"/>	Work environment: basement office						
No <input checked="" type="checkbox"/>							
Work at a computer?	<table border="0"> <tr> <td>Yes <input checked="" type="checkbox"/></td> <td rowspan="2">If yes, for how many hours? Typically 10+ hours</td> </tr> <tr> <td>No <input type="checkbox"/></td> </tr> </table>	Yes <input checked="" type="checkbox"/>	If yes, for how many hours? Typically 10+ hours	No <input type="checkbox"/>			
Yes <input checked="" type="checkbox"/>	If yes, for how many hours? Typically 10+ hours						
No <input type="checkbox"/>							

**BRIGHTON SCHOOL OF MASSAGE – CLIENT CONSULTATION FORM**

Do you smoke?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	No. per day:		
Do you drink alcohol?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Units per week: <i>Average 1 unit daily. Pub 3x week. Beer.</i>		
Do you exercise?	None <input checked="" type="checkbox"/> Occasional <input type="checkbox"/> Irregular <input type="checkbox"/> Regular <input type="checkbox"/>	Type/s of exercise: <i>U</i>		
Stress level (1-10 rating)	At work <i>4</i> At home <i>3</i>	Notes: <i>Client rates stress</i>		
Reasons for stress				
<b>Diet</b>				
Do you eat regular meals?	Breakfast <input checked="" type="checkbox"/> Lunch <input checked="" type="checkbox"/> Dinner <input checked="" type="checkbox"/>			
Do you eat in a hurry?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Do you take any food/vitamin supplements?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
How many portions of each of these items does your diet contain per day?	Fresh fruit <i>2</i>	Fresh vegetables <i>3</i>	Protein <i>3</i>	Protein source? <i>Meat, chicken</i>
	Dairy produce <i>3</i>	Sweet things <i>3</i>	Added salt <i>1</i>	Added sugar <i>3</i>
How many units of these drinks do you consume per day?	Tea <i>3</i>	Coffee <i>0</i>	Fruit juice <i>2</i>	
	Water <i>4</i>	Soft drinks <i>0</i>	Other <i>0</i>	
Do you suffer from food allergies?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Details:		
Do you experience disordered eating?	Bingeing <input type="checkbox"/> Overeating <input type="checkbox"/> Undereating <input type="checkbox"/>	Notes: <i>Healthy attitude to food.</i>		
<b>Consultation Notes</b>				
Client profile	<p><i>Tim is a 45 year old divorced man who is self-employed in IT. Works from home in a basement flat. Can sometimes go for a few days without going outside. Loves his job but sometimes stressful as not sure where next account is coming from.</i></p> <p><i>Meets friends 3x weekly at the pub. Cooks own food typically, but has a sweet tooth and often eats too much of the wrong food. Always eats in a hurry and often feels bloated.</i></p> <p><i>He is very tall and suffers from kyphosis through bad posture which leads to ongoing back and neck pain with headaches almost daily. He rarely exercise and sometimes feels depressed.</i></p>			
Additional Notes				

**BRIGHTON SCHOOL OF MASSAGE – CLIENT CONSULTATION FORM**

Treatment Record	
Treatment Date and Location	05/11/2020. Therapy Rooms
Treatment plan	Course of three IHM at weekly intervals concentrating on back, neck, shoulders and scalp. Happy to use olive oil on scalp for its anti-inflammatory properties.
Medium used	Olive Oil – scalp only
Client signature	Please sign here to agree and consent to the proposed treatment plan.
To be signed before treatment.	Sign: <span style="color: purple;">signed by client</span> Date: <span style="color: purple;">5/11</span>
Treatment Notes	
Details of how treatment was conducted	As expected, Tim held huge amount of tension in neck and shoulders and at the beginning of the massage his back felt rigid and stiff. Because of this I added extra effleurage, kneading and champissage over his upper back and shoulders. Tim wanted to talk but I suggested that he focussed on slow deep breaths to aid relaxation. Seemed to be finding it hard to relax but when I began massaging scalp, with small amount of olive oil, I felt him relax suddenly, which he remained.
Details of how the client felt during and after the treatment	Tim commented that initially he found it hard to relax, even though he was enjoying the massage. Once begun the scalp massage, he absolutely adored it and wished he'd discovered IHM years ago. He could not believe how different his neck and head now felt.
Specific aftercare and home care advice given	Advised Tim to go home and relax, drink plenty of water (at least 3 glasses) and have a light evening meal. As Tim had not had IHM previously, explained the possible side effects and told him not to worry if he did feel a little under the weather and if that happened to keep hydrated and that it shouldn't last >24hrs. Recommended Tim should start to get into daily walk habit – daylight to help mood & exercise and decrease stress. Should be aware of posture whilst sitting at computer. He's aware of sitting badly but hasn't yet prioritised rectifying it. Eat slower, might mean less bloating sensation.
Reflective practice and action for next treatment	I found Tim hard to massage as the tension in his back and neck was so great he found it difficult to sit up correctly and I found I was leaning forward to compensate. I also need a slightly larger support for his head during the face massage.
Therapist Signature	Please sign here to confirm information is correct.
	Sign: <span style="color: blue;">Joanna Sherman</span> Date: <span style="color: blue;">05/11/2020</span>

**BRIGHTON SCHOOL OF MASSAGE – CLIENT CONSULTATION FORM**

<b>Follow Up Treatment Record</b>	
<b>Treatment Date and Location</b>	12/11/2020. Therapy Rooms
<b>Client comments following previous treatment</b>	Tim had a bad headache after his first treatment which lasted until the morning. He asked if he was likely to have another bad headache after today's treatment which I said was less likely. Tim said his shoulders felt so much better but his neck was still tight and stiff and he had still been getting headaches though they were not as bad. He was really looking forward to today's treatment.
<b>Reason for treatment</b>	Continuation of treatment plan.
<b>Treatment plan</b>	Concentrate on back, neck, shoulders and scalp.
<b>Medium used</b>	Olive oil – scalp only
<b>Client signature</b>  <i>To be signed before treatment.</i>	Please sign here to agree and consent to the proposed treatment plan.  Sign: <i>signed by client</i> <span style="float: right;">Date: <i>12/11/20</i></span>
<b>Treatment Notes</b>	
<b>Details of how treatment was conducted</b>	Tim still had a lot of tension in his upper back but today he closed his eyes, focused on breathing and relaxed straight away. I used deeper effleurage, kneading and frictions than last week to try to alleviate as much tension as I could. Used olive oil in scalp massage (Tim had commented that he liked how it felt after he washed + last time).
<b>Details of how the client felt during and after the treatment</b>	Tim was very relaxed and he commented that he had felt more relaxed right from the start this time.
<b>Specific aftercare and home care advice given</b>	Tim remembered the previous advice and said he will drink more water for the rest of the day. Had walked nearly every morning, and felt happier than he had for a while. Tim is finding improving work posture quite challenging. He eats meals in front of computer, so suggested to start by eating at a different table for desk-free time.
<b>Follow Up Treatment Plan</b>	Final planned treatment next week.
<b>Reflective Practice</b>	
<b>Reflection on treatment given</b>	I still found it hard to maintain good posture while massaging Tim, but the larger support helped when massaging face. I was happy with the pressure I used and felt my champissage had improved since last treatment
<b>Therapist Signature</b>	Please sign here to confirm information is correct.  Sign: <i>Joanna Sherman</i> <span style="float: right;">Date: <i>12/11/2020</i></span>

**BRIGHTON SCHOOL OF MASSAGE – CLIENT CONSULTATION FORM**

<b>Follow Up Treatment Record</b>	
<b>Treatment Date and Location</b>	17/11/2020. Therapy Rooms
<b>Client comments following previous treatment</b>	Tim did not have a headache after last week's massage and said he felt wonderful for at least four days afterwards, but he is still getting headaches most days. Time is looking forward to today's treatment.
<b>Reason for treatment</b>	Continuation.
<b>Treatment plan</b>	Focus on same problem areas.
<b>Medium used</b>	
<b>Client signature</b>	Please sign here to agree and consent to the proposed treatment plan.
<i>To be signed before treatment.</i>	Sign: <span style="color: purple;">signed by client</span> Date: 12/11/20
<b>Treatment Notes</b>	
<b>Details of how treatment was conducted</b>	I used deeper pressure again this week as it seemed to make such a difference to how Tim felt during the week. Although there was still a lot of tension in his upper back and neck, it did seem a little more pliable than the previous weeks.
<b>Details of how the client felt during and after the treatment</b>	Tim again felt wonderful and was very complementary about my massage. He felt the pressure was firmer than the week before which he really liked.
<b>Specific aftercare and home care advice given</b>	Tim was still walking almost every day and said he felt a lot better for it. He was still trying to improve his working posture. He shared that he is considering investing in a better chair. He was still eating in front of the computer at his desk and still eating in a hurry. I recommended that because of the headaches and neck pain that it might be a good idea to see a chiropractor or osteopath as it is possible his neck needs an adjustment.
<b>Follow Up Treatment Plan</b>	Tim plans to continue with fortnightly massage.
<b>Reflective Practice</b>	
<b>Reflection on treatment given</b>	Tim was so happy with his I+HMs. He has done a lot for my confidence and I think that helped me give a firmer massage this week. I am also finding the routine much easier to remember now and because of that, I think, my massage and posture has improved nicely.

**BRIGHTON SCHOOL OF MASSAGE – CLIENT CONSULTATION FORM**

<p><b>Overall Summary of case study</b></p>	<p>Tim was very pleased with the outcome. His neck and back felt better than it had in years and although he was still getting headaches, they were not as bad as before. He felt going out every day had made such a difference to the way he felt mentally. He also said that he would bear in mind that he should be eating slower, and if he does remember to do that, he will see if it makes a difference to his bloating Tim said that he will contact the chiropractor that I recommended. He would like to continue with fortnightly massage.</p>
<p><b>Action plan for continual professional development</b></p>	<p>To research some more specific advice for resolving poor desk posture. I would like to have three pieces of practical advice to give Tim when I see him in two weeks.</p>
<p><b>Therapist Signature</b></p>	<p>Please sign here to confirm information is correct.</p> <p>Sign:                  Joanna Sherman                                  Date: 12/11/2020</p>