Consultation Form

**Please answer the following questions to enable you to be given a safe and effective treatment. You may be asked to obtain approval and advice from your Doctor or any healthcare professional involved in your welfare before starting massage treatment.**

**Any information given below is treated in the strictest confidence and no additional information will be sought without your prior permission.**

Conducting subjective and objective assessment

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| **Centre name:** |  |
| **Learner name:** |  |
| **Date:** |  |

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| **Client name:** |  |
| **Address:** |  |
| **Profession:**  |  |
| **Telephone number:** | Day: |  |
| Evening: |  |

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| Personal details: |
| Age group: | Under 20 ☐ | 20 – 30 ☐ | 30 – 40 ☐ | 40 – 50 ☐ | 50 – 60 ☐ | 60+ ☐ |
| Lifestyle: | Active ☐ | Sedentary ☐ |
| Last visit to the doctor: |  |
| GP address: |  |
| Number of children:*(If applicable)* |  |
| Date of last period:*(If applicable)* |  |

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| The client’s reason for the sports massage treatment and what the she or he would like to achieve |
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| Contra-indications requiring medical permission – *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment* *(Select if/where appropriate):* |
| Pregnancy  | ☒ | Epilepsy  | ☐ | Cancer  | ☐ |
| Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)  | ☐ | Recent operations  | ☐ | Postural deformities  | ☐ |
| Haemophilia  | ☐ | Diabetes  | ☐ | Spastic conditions  | ☐ |
| Any condition already being treated by a GP or another health professional, e.g., Physiotherapist, Osteopath, Chiropractor, Coach  | ☐ | Any dysfunction of the nervous system (e.g., Muscular sclerosis, Parkinson’s disease, Motor neurone disease)  | ☐ | Kidney infections  | ☐ |
| Medical oedema  | ☐ | Bell’s palsy  | ☐ | Whiplash  | ☐ |
| Osteoporosis  | ☐ | Trapped/Pinched nerve (e.g., sciatica)  | ☐ | Slipped disc  | ☐ |
| Arthritis  | ☐ | Inflamed nerve  | ☐ | Undiagnosed pain  | ☐ |
| When taking prescribed medication | ☐ | Acute rheumatism | ☐ | Nervous/psychotic conditions | ☐ |

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| Contra-indications that restrict treatment *(Select if/where appropriate):* |
| Fever  | ☐ | Varicose veins  | ☐ | Sunburn  | ☐ |
| Contagious or infectious diseases  | ☐ | Pregnancy (abdomen)  | ☐ | Hormonal implants  | ☐ |
| Under the influence of recreational drugs or alcohol  | ☐ | Cuts  | ☐ | Abdomen (first few days of menstruation depending how the client feels)  | ☐ |
| Diarrhoea and vomiting  | ☐ | Bruises | ☐ | Haematoma  | ☐ |
| Skin diseases  | ☐ | Varicose veins  | ☐ | Hernia  | ☐ |
| Undiagnosed lumps and bumps  | ☐ | Abrasions  | ☐ | Recent fractures (minimum 3 months)  | ☐ |
| Localised swelling  | ☐ | Scar tissue (2 years for major operation and 6 months for a small scar)  | ☐ | Cervical spondylitis  | ☐ |
| Gastric ulcers | ☐ | After a heavy meal | ☐ | Inflammation | ☐ |

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| Written permission required by(either of which should be attached to the consultation form):–  |
| GP/specialist ☐ | Informed consent ☐ |

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| Pre-existing conditions/disease processes (therapeutic and remedial): |
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| Personal information *(Select if/where appropriate):* |
| Muscular/skeletal problems: | Back | ☐ | Aches/pain | ☐ | Stiff joints | ☐ | Headaches | ☐ |
| Digestive problems: | Constipation | ☐ | Bloating | ☐ | Liver/gall bladder | ☐ | Stomach | ☐ |
| Circulation: | Heart | ☐ | Blood pressure | ☐ | Fluid retention | ☐ | Tired legs | ☐ |
| Varicose veins | ☐ | Cellulite | ☐ | Kidney problems | ☐ | Cold hands and feet | ☐ |
| Gynaecological: | Irregular periods | ☐ | P.M.T | ☐ | Menopause | ☐ | H.R.T | ☐ |
| Pill | ☐ | Coil | ☐ | Other | ☐ |
| Nervous system: | Migraine | ☐ | Tension | ☐ | Stress | ☐ | Depression | ☐ |
| Immune system: | Prone to infections | ☐ | Sore throats | ☐ | Colds | ☐ |
| Sinuses | ☐ | Chest | ☐ |
| Current medical condition/Treatment | Pain nature onset | ☐ | Duration | ☐ | Daily pain pattern: |  |
| Aggravates sitting | ☐ | Standing | ☐ | Walking | ☐ | Running | ☐ |



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| History of present condition (select if/where appropriate): |
| Recurring injury | Yes | ☐ | No | ☐ |
| What treatment was undertaken? |  |
| How long did the injury take to heal?  |  |
| Did you have any investigations?  | Yes | ☐ | No | ☐ | If yes, which ones: |  |
| Regularantibiotic/medication taken? | Yes | ☐ | No | ☐ | If yes, which ones: |  |
| Herbal remedies taken? | Yes | ☐ | No | ☐ | If yes, which ones: |  |
| Ability to relax: | Good | ☐ | Moderate | ☐ | Poor | ☐ |
| Sleep patterns: | Good | ☐ | Poor | ☐ | Average no. of hours |  |
| Do you see natural daylight in your workplace? | Yes | ☐ | No | ☐ |
| Do you work at a computer? | Yes | ☐ | No | ☐ | If yes, how many hours |  |
| Do you eat regular meals? | Yes | ☐ | No | ☐ |
| Do you eat in a hurry? | Yes | ☐ | No | ☐ |
| Do you take any food/vitamin supplements? | Yes | ☐ | No | ☐ | If so, which ones? |  |
| How many portions of each of these items does your diet contain per day? | Fresh fruit: |  | Fresh vegetables: |  | Protein and 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: |  | Others: |  |
| Do you suffer from food allergies? | Yes | ☐ | No | ☐ |
| Bingeing? | Yes | ☐ | No | ☐ |
| Overeating? | Yes | ☐ | No | ☐ |
| Do you smoke? | Yes | ☐ | No | ☐ | How many a day? |  |
| Do you drink alcohol? | Yes | ☐ | No | ☐ | How many units a day? |  |
| Do you exercise? | None | ☐ | Occasional | ☐ | Irregular | ☐ | Regular | ☐ |
| Types: |  |
| What is your skin type? | Dry | ☐ | Oily | ☐ | Combination | ☐ | Sensitive | ☐ | Dehydrated | ☐ |
| Do you suffer/have you suffered from | Dermatitis | ☐ | Acne | ☐ | Eczema | ☐ | Psoriasis | ☐ |
| Allergies | ☐ | Hay Fever | ☐ | Asthma | ☐ | Skin cancer | ☐ |
| Stress level 1–10 (10 being the highest): | At work | ☐ | At home | ☐ |

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| **Physical examination:** |
| Observations: |  |
| Head: |  |
| Shoulders: |  |
| Back: |  |
| Pelvis: |  |
| Legs: |  |
| Feet: |  |
| Body alignment/ posture: |  |



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| Palpations: |
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| Functional tests: |
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| **Joint movement tested: to include spinal range and movement of the upper and lower limbs** |
| Joint/active/passive ROMPre-treatment  | Right | Left | MET | RightPost-treatment  | LeftPost-treatment |
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| Muscle tests – Isometric strength testing(resisted): |
| Muscle group | Right | Left |
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| Muscle length tests |  |  |
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| Muscle bulk |  |  |
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| Special tests: |
| Test | Right | Left | Comments |
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| Treatment plan and state rationale for chosen massage interventions: |
| **Hypothesis:****Treatment Plan:****Rationale:** |

**I** confirm that the above information I given is accurate to the best of my knowledge.

I will keep my therapist up to date with any changes to my physical health.

I know no reason why I should not receive treatment.

I understand that treatments undertaken by me at my own risk and that the therapist may not be able to cure my complaint.

I understand and agree to receive the treatment explained to me by the therapist.

**Learner signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_