Client 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.**

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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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| Contra-indications requiring medical permission *(Select if/where appropriate):* |
| Pregnancy | ☐ | Acute trauma | ☐ | Postural deformities | ☐ |
| Thrombosis, phlebitis, hypertension, hypotension, heart conditions) | ☐ | Open wounds  | ☐ | Spastic conditions | ☐ |
| Haemophilia | ☐ | Acute soft tissue injury | ☐ | Kidney infections | ☐ |
| Any condition already being treated by a GP or another health professional, e.g., physiotherapist, osteopath, chiropractor, coach | ☐ | Periostitis | ☐ | Whiplash | ☐ |
| Medical oedema | ☐ | Risk of haemorrhage | ☐ | Slipped disc | ☐ |
| Osteoporosis | ☐ | Asthma | ☐ | Undiagnosed pain | ☐ |
| Arthritis | ☐ | Any dysfunction of the nervous system (e.g., multiple sclerosis, Parkinson’s disease, motor neurone disease) | ☐ | When taking prescribed medication | ☐ |
| Nervous/psychotic conditions | ☐ | Bell’s palsy | ☐ | Acute rheumatism | ☐ |
| Epilepsy | ☐ | Trapped/pinched nerve (e.g., sciatica)  | ☐ | Tumour | ☐ |
| Recent operations | ☐ | Inflamed nerve | ☐ | Frostbite | ☐ |
| Diabetes | ☐ | Cancer | ☐ | Bursitis | ☐ |
| Myositis ossificans | ☐ | Mental incapacity | ☐ |

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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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| **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 | ☐ |
| Regular antibiotic/ 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 | ☐ |

**Therapist/learner signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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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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| Physical examination *(Select if/where appropriate):* |
| **Postural assessment**  |
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| Head: |  |
| Shoulders: |  |
| Back: |  |
| Pelvis: |  |
| Legs: |  |
| Feet: |  |
| Body alignment/posture: |  |

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| Palpation | Other ( e.g. bruising, swelling, atrophy, etc) |
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| Treatment plan (including pre-event, post-or maintenance) and rational  |
| **Aims for treatment :****How to achieve this :** |

**Therapist/learner signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| Treatment given and observation ( maintenance, pre-event , post-event ) |
| **Treatment given :****Prone:****Supine :****Observation :** |

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| Client feedback  |
| **During the treatment** **After treatment**  |

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| Home care/aftercare advice: |
| **Stretching , etc**  |

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| Reflective practice |
| **What went well?****What would you do differently next time?** |