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

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

**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?** |