Client Consultation/Assessment Evidence Form

iUSP158 – Conduct complex assessment for sports massage

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

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

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)*						

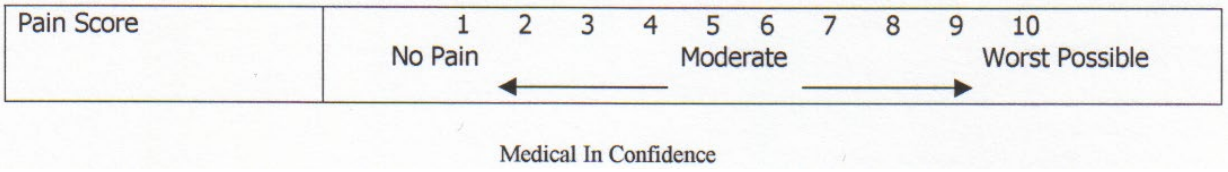
Contra-indications requiring medical permission – *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):*					
Pregnancy	☐	Recent operations	☐	Spastic conditions	☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Diabetes	☐	Kidney infections	☐
Haemophilia	☐	Asthma	☐	Whiplash	☐
Any condition already being treated by a GP or another health professional e.g. physiotherapist, osteopath, chiropractor or coach	☐	Any dysfunction of the nervous system e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease	☐	Slipped disc	☐
Medical oedema	☐	Bell's palsy	☐	Undiagnosed pain	☐
Osteoporosis	☐	Trapped/pinched nerve e.g. sciatica	☐	When taking pra)escribed medication	☐
Arthritis	☐	Inflamed nerve	☐	Acute rheumatism	☐
Nervous/psychotic conditions	☐	Cancer	☐	Epilepsy	☐
Postural deformities	☐				

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

Written permission required by GP/Specialist – *Either of which should be attached to the treatment form (Select if/where appropriate):*			
Yes	☐	No	☐

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:	
Are you pregnant or trying for a baby?	Yes ☐		No ☐	
Nervous system:	Migraine ☐	Tension ☐	Stress ☐	Depression ☐
Immune system:	Prone to infections ☐	Sore throats ☐	Colds ☐	Chest ☐
	Sinuses ☐			

Current medical condition/treatment – *(Select if/where appropriate):*			
Pain nature onset ☐	Duration ☐	Daily pain pattern:	
Aggravates sitting ☐	Standing ☐	Walking ☐	Running ☐



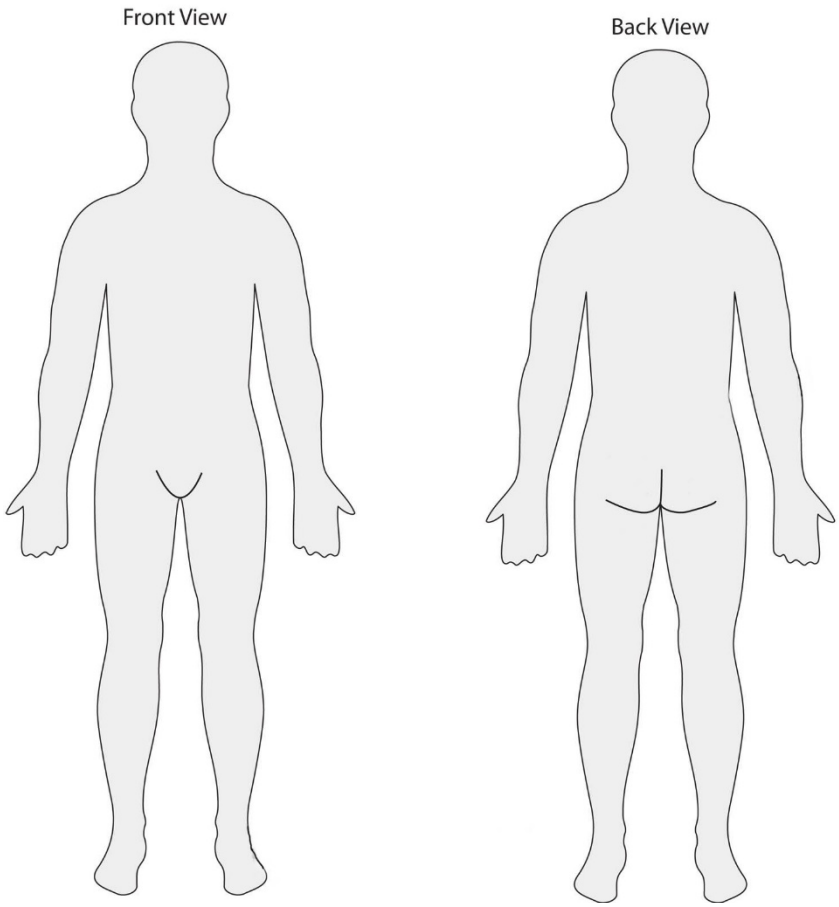
History of present condition			
Recurring injury	Yes ☐	No ☐	
What treatment was undertaken?			
How long did the injury take to heal?			
Did you have any investigations?	Yes ☐	No ☐	If yes, which ones:

Regular antibiotic/medication taken?		
If yes, which ones:	Yes ☐	No ☐
Herbal remedies taken?		
If yes, which ones:	Yes ☐	No ☐

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 yes, 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 ☐		
Do you smoke?	Yes ☐	No ☐	How many per day:	
Do you drink alcohol?	Yes ☐	No ☐	How many units per day:	
Do you exercise?	None ☐	Occasional ☐	Irregular ☐	Regular ☐
	Type:			
What is your skin type?	Dry ☐	Oily ☐	Combination ☐	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:		

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



Assessment:	
To include:	
Palpations:	

Joint movement tested: to include spinal range and movement of the upper and lower limbs					
Joint/active/ passive ROM	Right	Left	Joint/active/ passive ROM	Right	Left

Muscle tests – isometric strength testing		
Muscle group	Right	Left
Muscle length tests		
Muscle bulk		

Special tests – ligamentous and neural			
Test	Right	Left	Comments

Functional tests:	
Full postural analysis of symmetry and examination:	
Gait analysis:	
Range of movement findings, identifying strengths and areas for improvement:	
Pre-existing conditions/disease processes: (therapeutic and remedial)	
Devise treatment plan and massage strategies:	
Rational for chose massage strategies:	

Therapist/Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	03/09/2019	First published	Qualifications and Regulation Co-ordinator