

Client Consultation Form

iUSP178 – Sports massage treatments

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

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

Personal details:						
Age group:	Under 20 <input type="checkbox"/>	20 – 30 <input type="checkbox"/>	30 – 40 <input type="checkbox"/>	40 – 50 <input type="checkbox"/>	50 – 60 <input type="checkbox"/>	60+ <input type="checkbox"/>
Lifestyle:	Active <input type="checkbox"/>			Sedentary <input type="checkbox"/>		
Last visit to the doctor:						
GP address:						
Number of children: (If applicable)						
Date of last period: (If applicable)						

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

Written permission required by <i>(either of which should be attached to the consultation form):</i>	
GP/specialist <input type="checkbox"/>	Informed consent <input type="checkbox"/>

Personal information <i>(Select if/where appropriate):</i>				
Muscular/skeletal problems:	Back <input type="checkbox"/>	Aches/pain <input type="checkbox"/>	Stiff joints <input type="checkbox"/>	Headaches <input type="checkbox"/>
Digestive problems:	Constipation <input type="checkbox"/>	Bloating <input type="checkbox"/>	Liver/gall bladder <input type="checkbox"/>	Stomach <input type="checkbox"/>
Circulation:	Heart <input type="checkbox"/>	Blood pressure <input 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"/>
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"/>	Other <input type="checkbox"/>	

Nervous system:	Migraine <input type="checkbox"/>	Tension <input type="checkbox"/>	Stress <input type="checkbox"/>	Depression <input type="checkbox"/>
Immune system:	Prone to infections <input type="checkbox"/>	Sore throats <input type="checkbox"/>	Colds <input type="checkbox"/>	
	Sinuses <input type="checkbox"/>		Chest <input type="checkbox"/>	
Regular antibiotic/ medication taken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, which ones?	
Herbal remedies taken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, which ones?	
Ability to relax:	Good <input type="checkbox"/>	Moderate <input type="checkbox"/>	Poor <input type="checkbox"/>	
Sleep patterns:	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	Average no. of hours:	
Do you see natural daylight in your workplace?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Do you work at a computer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, how many hours?	
Do you eat regular meals?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Do you eat in a hurry?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Do you take any food/vitamin supplements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	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 <input type="checkbox"/>		No <input type="checkbox"/>	
Bingeing?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Overeating?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	

Do you smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many a day?		
Do you drink alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many units a day?		
Do you exercise?	None <input type="checkbox"/>	Occasional <input type="checkbox"/>	Irregular <input type="checkbox"/>	Regular <input type="checkbox"/>	
	Types:				
What is your skin type?	Dry <input type="checkbox"/>	Oily <input type="checkbox"/>	Combination <input type="checkbox"/>	Sensitive <input type="checkbox"/>	Dehydrated <input type="checkbox"/>
Do you suffer/have you suffered from	Dermatitis <input type="checkbox"/>	Acne <input type="checkbox"/>	Eczema <input type="checkbox"/>	Psoriasis <input type="checkbox"/>	
	Allergies <input type="checkbox"/>	Hay fever <input type="checkbox"/>	Asthma <input type="checkbox"/>	Skin cancer <input type="checkbox"/>	
Stress level 1–10 (10 being the highest):	At work <input type="checkbox"/>		At home <input type="checkbox"/>		

Physical examination <i>(Select if/where appropriate):</i>	
Head:	
Shoulders:	
Back:	
Pelvis:	
Legs:	
Feet:	
Body alignment/posture:	

Client feedback:

Reflect on feedback received and self-analysis of treatment:

Home care/aftercare advice:

Therapist/learner signature: _____

Client signature: _____

Date: _____

Document History

Version	Issue Date	Changes	Role
v1	27/09/2019	First published	Qualification Administrator
v2	19/12/2019	Punctuation and table fixes	Qualification Administrator