

Unit iUSP158 – L5 Conduct complex assessment for sports massage

College Name:
 College Number:
 Student Name:
 Client Name:
 Profession:
 GP Address:
 Last visit to the doctor:

PERSONAL DETAILS:

Age group: Under 20 20-29 30-39 40-49
 50-59 60+
Lifestyle: Active Sedentary Both
No. of children (if applicable):
Date of last period (if applicable:):

CONTRAINDICATIONS that require medical permission (select if/where appropriate):

<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	<input type="checkbox"/> Recent operations	<input type="checkbox"/> Spinal conditions (e.g.cerebral palsy)
<input type="checkbox"/> Haemophilia	<input type="checkbox"/> Diabetes	<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"/> Acute trauma	<input type="checkbox"/> Whiplash
<input type="checkbox"/> Medical oedema	<input type="checkbox"/> Open wounds	<input type="checkbox"/> Slipped disc
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Acute soft tissue injury	<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"/> Are you taking prescribed medication?
<input type="checkbox"/> Anxiety/stress/depression medication	<input type="checkbox"/> Bell's Palsy	<input type="checkbox"/> Acute rheumatism
	<input type="checkbox"/> Trapped/Pinched nerve (e.g.sciatica)	<input type="checkbox"/> Thyroid Disorders
	<input type="checkbox"/> Inflamed nerve	<input type="checkbox"/> Severe Allergies (that require medical attention e.g. nuts)
	<input type="checkbox"/> Postural deformities	

Please give details of any other diagnosed medical condition that is not listed above:

CONTRAINDICATIONS THAT RESTRICT TREATMENT (select if/where appropriate):

<input type="checkbox"/> Fever	<input type="checkbox"/> Cuts	<input type="checkbox"/> Bruises	<input type="checkbox"/> Abrasions
<input type="checkbox"/> Contagious or infectious diseases	<input type="checkbox"/> Scar tissue (2 years for major operation and 6 months for a small scar)		
<input type="checkbox"/> Under the influence of recreational drugs or alcohol	<input type="checkbox"/> Sunburn		
<input type="checkbox"/> Diarrhoea and vomiting	<input type="checkbox"/> Hormonal Implants		
<input type="checkbox"/> Skin diseases	<input type="checkbox"/> Menstruation (abdomen -1 st few days)		
<input type="checkbox"/> Undiagnosed lumps and bumps	<input type="checkbox"/> Haematoma		
<input type="checkbox"/> Localised swelling	<input type="checkbox"/> Hernia		
<input type="checkbox"/> Inflammation	<input type="checkbox"/> Cervical Spondylitis		
<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Recent fractures (min 3 months)		
<input type="checkbox"/> Pregnancy (abdomen)	<input type="checkbox"/> Gastric ulcers		
	<input type="checkbox"/> After a heavy meal		

WRITTEN PERMISSION REQUIRED BY GP/SPECIALIST (which should be attached to the consultation form):

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:

Nervous system: Migraine Tension Stress
Depression

Immune system: Prone to infections Sore throats
Colds Chest Sinuses

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. hours:

Do you see natural daylight at work? 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:

What do you eat for...

Breakfast:
Lunch
Dinner:

Do you eat (regularly): Sweet things: Added salt:
Added Sugar:

Do you restrict any food groups? Yes No
If so, what?

How many units of drinks do you consume per day?

Tea: Coffee: Fruit juice: Water:
Soft Drinks: Other:

Do you suffer from food allergies? Yes No
If yes, what?

Does stress affect your eating habits? Yes No
If so, how?

Do you smoke? Yes No How many per day?

Do you drink alcohol? Yes No Units per week?

Do you exercise? None Occasional Irregular
Regular Type:

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

Do you suffer from allergic skin reactions? Yes No
If so, to what?

Stress level: 1-10 (10 being the highest)

At work At home

Right handed Left handed

CURRENT MEDICAL CONDITION/TREATMENT

INJURY LOCATION:

Subjective Assessment:

(How did it happen, when did it happen, S&S, neurological presentations, immediate/ongoing treatment, type of pain, location of pain (superficial/deep), change in footwear, change in training, previous injuries etc)

Pain Nature:

Onset:

Duration:

Daily Pain Pattern:

Aggravating:

Sitting Standing Walking Running

Easing factors:

SIN:

HISTORY OF PRESENT CONDITION:

Recurring Injury? Yes No

Did you have any investigations? Yes No If yes, which ones:

PHYSICAL EXAMINATION

Observations:

Head:

Shoulders:

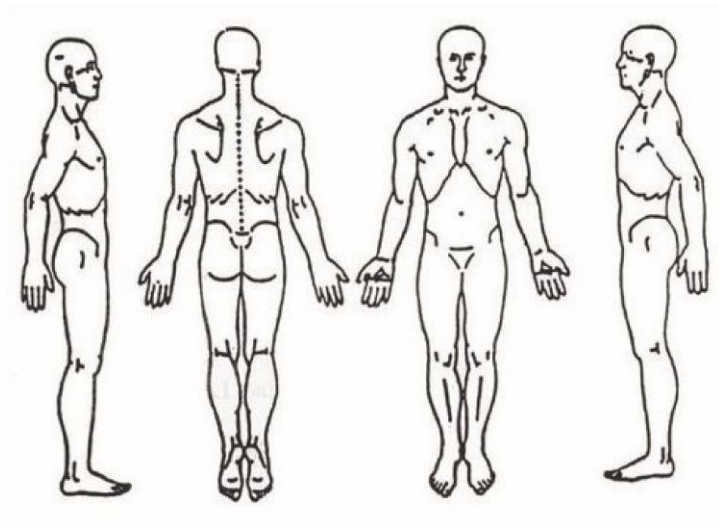
Back:

Pelvis:

Legs:

Feet:

Body Alignment/posture:



Assessment PLAN	
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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 – include any muscle length or bulk observations

Muscle Group	Right	Left
Muscle length tests		
Muscle Bulk		

Special Tests

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 of complex massage techniques:	
Rational for chosen massage strategies:	
Protocols to follow for the chosen complex massage techniques:	

TISSUE RESPONSE THROUGHOUT THE TREATMENT:

HOME CARE/AFTERCARE ADVICE:

EVALUATION OF THE PURPOSE AND BENEFITS OF EACH AFTERCARE METHOD GIVEN:

CLIENT FEEDBACK:

REFLECT ON FEEDBACK RECEIVED AND SELF-ANALYSIS OF TREATMENT:

ADAPT TREATMENT PLANS BASED ON THE EVALUATION OF THE TREATMENT:

HOW YOUR INFORMATION WILL BE USED

I take your privacy very seriously; your personal information will only be used for treatment purposes and will never be shared with any third parties, without express permission.

KEEPING IN TOUCH

From time to time, I would like to get in touch with you when I have information about new therapies and special offers that I think might be of interest to you. If you agree to being contacted in this way, please tick how you are happy to be contacted:

- Post Email Phone SMS

If you have ticked one or more of the boxes above, please note that you can change your preferences or remove your consent at any time by getting in contact with me.

By signing below, you agree that your medical history is accurate and correct, and you agree to all the above statements.

Client's Signature

Learner's/Therapist Signature

Date