Consultation Form

Cotswold Academy Complementary health & sport iTEC

Unit iUSP151 – L4 Sports Massage Treatments

Case Study No: **Treatment No:**

College Name: **Cotswold Academy**

College Number: **X1107**

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):*

- ☐ Pregnancy
- ☐ Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)
- ☐ Haemophilia
- ☐ Any condition already being treated by a GP or another health professional, e.g. Physiotherapist, Osteopath, Chiropractor, Coach
- ☐ Medical oedema
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Anxiety/stress/depression
- ☐ Epilepsy
- ☐ Recent operations
- ☐ Diabetes
- ☐ Acute trauma
- ☐ Acute soft tissue injury
- ☐ Any dysfunction of the nervous system e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease
- ☐ Bell's Palsy
- ☐ Trapped/Pinched nerve (e.g.sciatica)
- ☐ Inflamed nerve
- ☐ Cancer
- ☐ Postural deformities
- ☐ Spinal cord conditions (e.g.cerebral palsy)
- ☐ Kidney infections
- ☐ Whiplash
- ☐ Slipped disc
- ☐ Undiagnosed pain
- ☐ Acute rheumatism
- ☐ Thyroid Disorders
- ☐ Severe Allergies (that require medical attention e.g. nuts)
- ☐ Taking prescribed medication

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

CONTRAINDICTIONS THAT RESTRICT TREATMENT *(select if/where appropriate):*

- ☐ **Fever**
- ☐ **Contagious or infectious diseases**
- ☐ **Under the influence of recreational drugs or alcohol**
- ☐ **Diarrhoea and vomiting**

- ☐ Skin diseases
- ☐ Undiagnosed lumps and bumps
- ☐ Localised swelling
- ☐ Inflammation
- ☐ Varicose veins
- ☐ Pregnancy (abdomen)
- ☐ Cuts ☐ Bruises ☐ Abrasions
- ☐ Scar tissue (2 years for major operation and 6 months for a small scar)
- ☐ Sunburn
- ☐ Hormonal Implants
- ☐ Menstruation (abdomen -1st few days)
- ☐ Haematoma
- ☐ Hernia
- ☐ Recent fractures (min 3 months)
- ☐ Gastric ulcers
- ☐ After a heavy meal
- ☐ Cervical Spondylitis

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 ☐

PRE-EXISTING CONDITIONS/DISEASE PROCESSES (THERAPEUTIC AND REMEDIAL)

CURRENT MEDICAL CONDITION/TREATMENT

Pain Nature:
Onset
Duration
Daily Pain Pattern

Aggravates:
Sitting Standing Walking Running
Eases:

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:

PHYSICAL EXAMINATION

Head:

Shoulders:

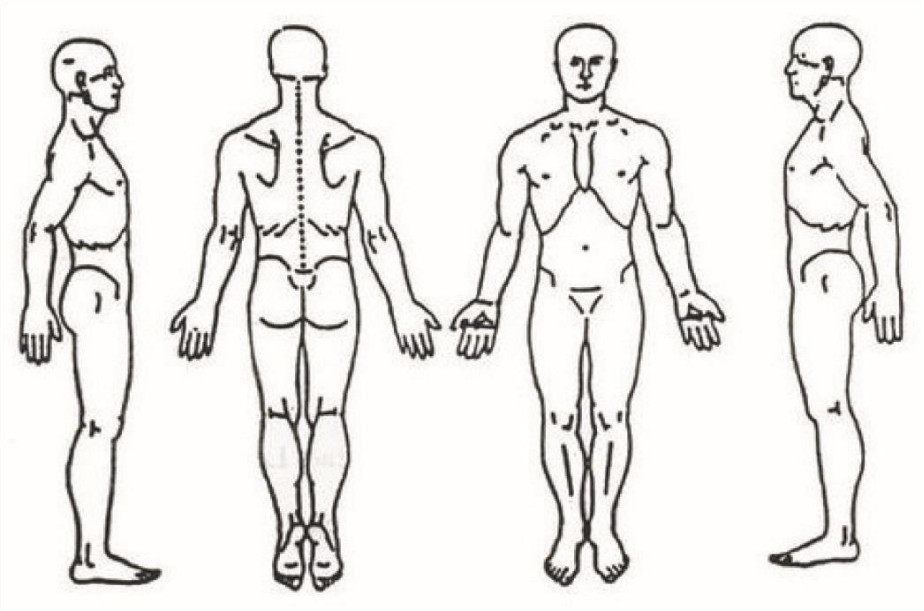
Back:

Pelvis:

Legs:

Feet:

Body alignment/posture:



FULL POSTURAL ANALYSIS OF SYMMETRY AND EXAMINATION (to include Palpation findings):

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

Special Tests

Test	Right	Left	Comments

FUNCTIONAL TESTS:

RANGE OF MOVEMENT FINDINGS, IDENTIFYING STRENGTHS AND AREAS FOR IMPROVEMENT:

DEVISE TREATMENT PLAN & STATE RATIONALE FOR CHOSEN MASSAGE INTERVENTIONS (MET, STR, Trigger point etc)

INJURY MANAGEMENT & PREVENTION:

TISSUE RESPONSE THROUGHOUT THE TREATMENT:

CLIENT FEEDBACK THROUGHOUT THE TREATMENT:

HOME CARE/AFTERCARE ADVICE GIVEN:

EVALUATION OF THE EFFECTIVENESS OF YOUR TREATMENT:

ADAPT FUTURE TREATMENT PLANS BASED ON THE EVALUATION OF THE TREATMENT:

DISCLAIMER/INFORMED CONSENT (select if/where appropriate):

I confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or Consultant.

You should note that if the student/therapist is unable to explain to you the contra indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your GP or Consultant.

It is **your responsibility** and not that of the student/therapist to consult your GP or Consultant.

By signing this form below, I hereby indemnify the student/therapist against any adverse reaction sustained as a result 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:

O Post O Email O Phone O 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

Continuation Form

Unit iUSP151 – L4 Sports Massage Treatments

CASE STUDY NO: **TREATMENT NO:**

Client Name:

Treatment date:

PHYSICAL EXAMINATION

Head:

Shoulders:

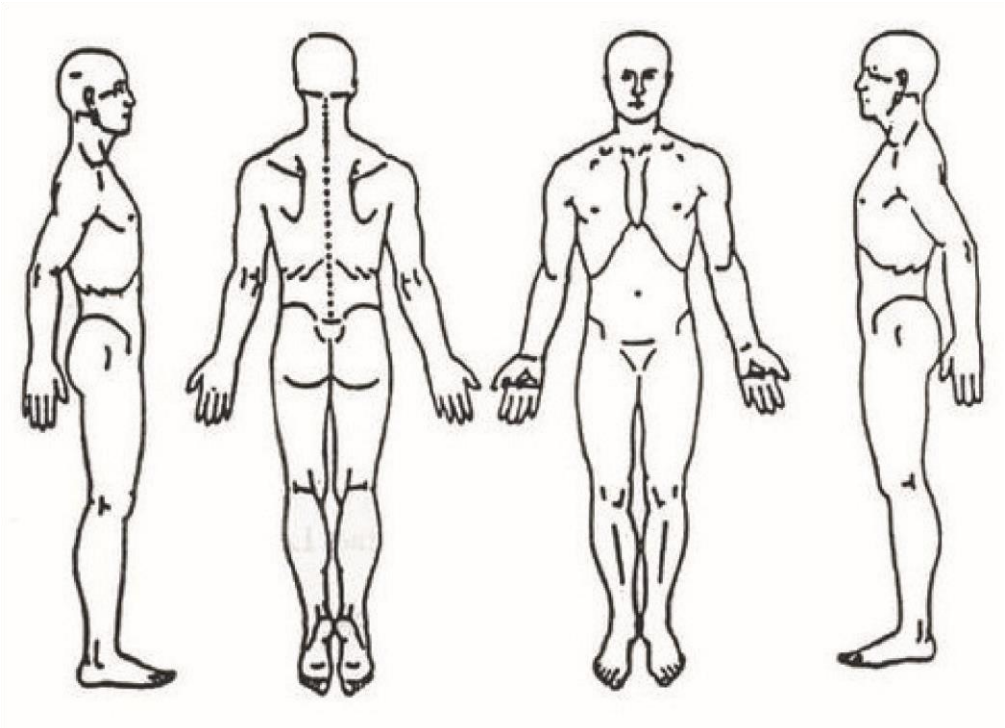
Back:

Pelvis:

Legs:

Feet:

Body alignment/posture:



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Client's signature

Learner's signature