Consultation Form

Cotswold Academy Complementary health & sport iTEC

Unit iUSP158 – L5 Conduct complex assessment for sports massage **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 medication
- ☐ Epilepsy
- ☐ Recent operations
- ☐ Diabetes
- ☐ Acute trauma
- ☐ Open wounds
- ☐ 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
- ☐ Postural deformities
- ☐ Cancer
- ☐ Spinal conditions (e.g.cerebral palsy)
- ☐ Kidney infections
- ☐ Whiplash
- ☐ Slipped disc
- ☐ Undiagnosed pain
- ☐ Are you taking prescribed medication?
- ☐ Acute rheumatism
- ☐ Thyroid Disorders
- ☐ Severe Allergies (that require medical attention e.g. nuts)

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
- ☐ Cervical Spondylitis
- ☐ Recent fractures (min 3 months)
- ☐ Gastric ulcers
- ☐ After a heavy meal

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:

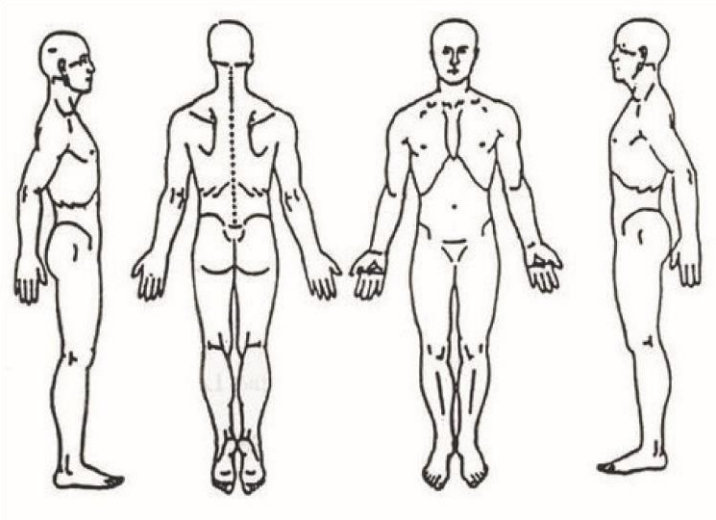
Back:

Pelvis:

Legs:

Feet:

Body Alignment/posture:



Assessment PLAN	

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:

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