Consultation Form

Cotswold Academy Complementary health & sport | iTEC

Unit 455/ iUSP178 - 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
- ☐ Myositis ossificans
- ☐ Acute trauma
- ☐ Open wounds
- ☐ Acute soft tissue injury
- ☐ Periostitis
- ☐ Risk of haemorrhage
- ☐ Asthma
- ☐ 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
- ☐ Tumour
- ☐ Frostbite
- ☐ Bursitis

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

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 ☐

PHYSICAL EXAMINATION

Head:

Shoulders:

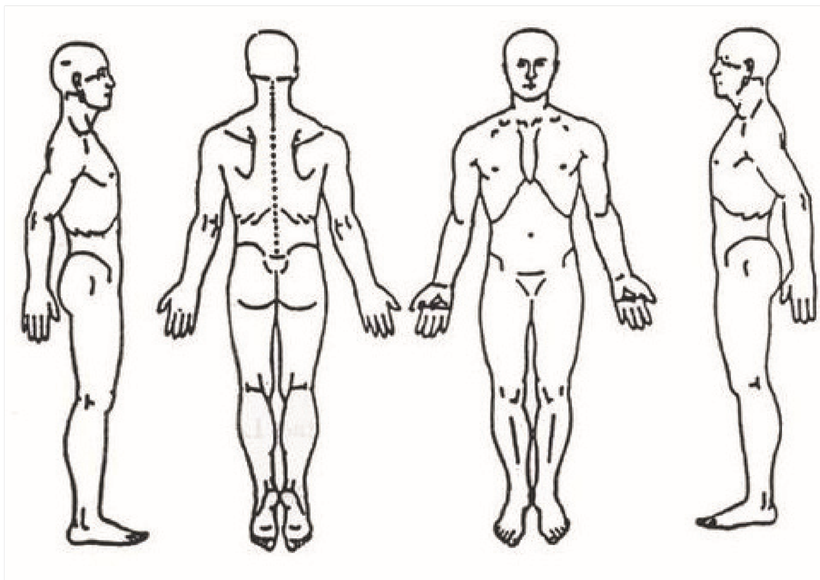
Back:

Pelvis:

Legs:

Feet:

Body alignment/posture:



SPORTS MASSAGE TREATMENT PLAN including pre-event, post-event and maintenance:

HOME CARE/AFTERCARE ADVICE:

CLIENT FEEDBACK:

REFLECT ON FEEDBACK RECEIVED AND SELF-ANALYSIS OF 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	

Treatment Continuation

iTEC

Cotswold Academy
Complementary health & sport

Unit 455/ iUSP178 - Sports Massage Treatments

CASE STUDY NO: | **TREATMENT NO:**

Client Name:

Treatment date:

PHYSICAL EXAMINATION

Head:

Shoulders:

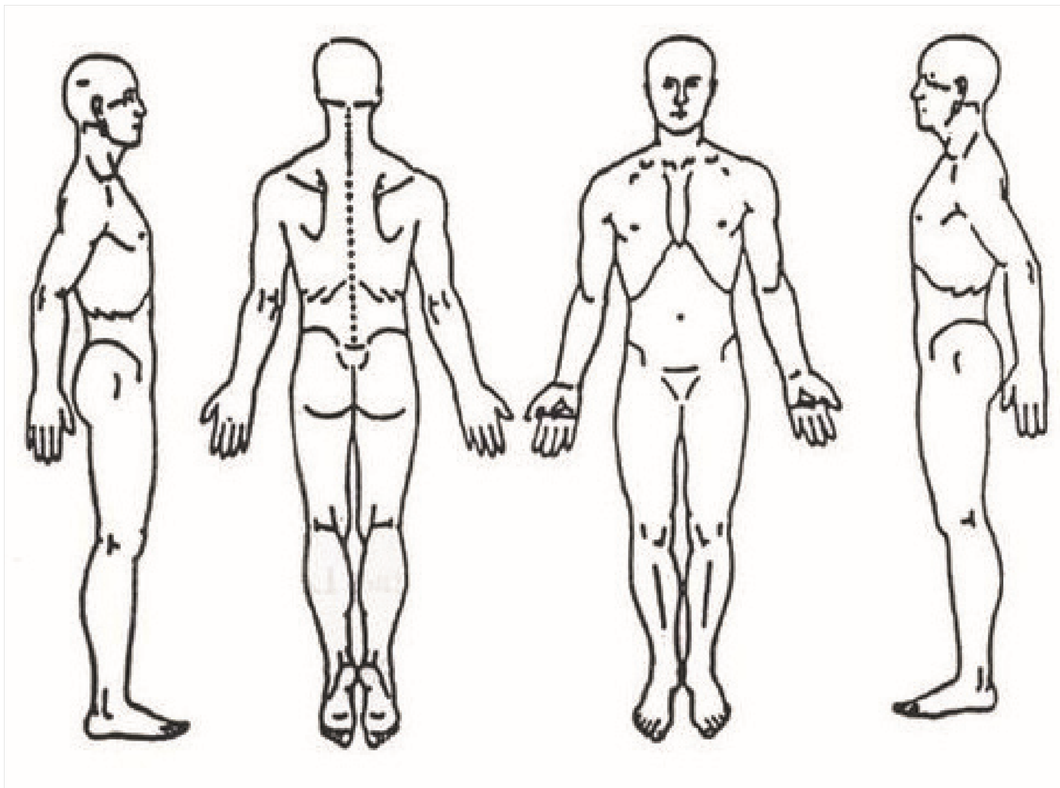
Back:

Pelvis:

Legs:

Feet:

Body alignment/posture:



REASON FOR SPORTS MASSAGE TREATMENT PLAN including pre-event, post-event and maintenance:

HOME CARE/AFTERCARE ADVICE:

CLIENT FEEDBACK:

REFLECT ON FEEDBACK RECEIVED AND SELF-ANALYSIS OF TREATMENT:

Client's signature	
Learner's signature	