Treatment Evidence Form

iUSP161 – Provide complex massage techniques for sports massage

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

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

Personal details:						
Age group:	Under 20 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Lifestyle:	Active ☐			Sedentary ☐		
Last visit to the doctor:						
GP address:						
Number of children: *(If applicable)*						
Date of last period: *(If applicable)*						

Contra-indications that require medical permission – *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):*

Pregnancy	☐	Epilepsy	☐	Cancer	☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Recent operations	☐	Postural deformities	☐
Haemophilia	☐	Diabetes	☐	Spastic conditions	☐
Any condition already being treated by a GP or another health professional, e.g., Physiotherapist, Osteopath, Chiropractor, Coach	☐	Asthma	☐	Kidney infections	☐
Medical oedema	☐	Any dysfunction of the nervous system (e.g., Multiple sclerosis, Parkinson's disease, Motor neurone disease)	☐	Whiplash	☐
Osteoporosis	☐	Bell's palsy	☐	Slipped disc	☐
Arthritis	☐	Trapped/pinched nerve (e.g. sciatica)	☐	Undiagnosed pain	☐
Nervous/psychotic conditions	☐	Inflamed nerve	☐	When taking prescribed medication	☐
Acute rheumatism	☐				

Contra-indications that restrict treatment *(Select if/where appropriate):*

Fever	☐	Inflammation	☐	Sunburn	☐
Contagious or infectious diseases	☐	Varicose veins	☐	Hormonal implants	☐
Under the influence of recreational drugs or alcohol	☐	Pregnancy (abdomen)	☐	Abdomen (first few days of menstruation depending how the client feels)	☐
Diarrhoea and vomiting	☐	Cuts	☐	Haematoma	☐
Skin diseases	☐	Bruises	☐	Hernia	☐
Undiagnosed lumps and bumps	☐	Abrasions	☐	Recent fractures (minimum 3 months)	☐
Localised swelling	☐	Scar tissue (2 years for major operation and 6 months for a small scar)	☐	Cervical spondylitis	☐
After a heavy meal	☐				

Written permission required by(either of which should be attached to the consultation form):–	
GP/specialist ☐	Informed consent ☐

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:			
	Are you pregnant or trying for a baby?					Yes ☐	No	☐
Nervous system:	Migraine	☐	Tension	☐	Stress	☐	Depression	☐
Immune system:	Prone to infections	☐	Sore throats	☐	Colds	☐	Chest	☐
	Sinuses	☐						

Current medical condition/treatment *(Select if/where appropriate):*

Pain nature onset	☐	Duration	☐	Daily pain pattern:	
Aggravates sitting	☐	Standing	☐	Walking ☐	Running ☐

Pain Score — 1 2 3 4 5 6 7 8 9 10 — No Pain / Moderate / Worst Possible

Medical In Confidence

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:	

Regular antibiotic/medication taken?					
If yes, which ones:				Yes ☐	No ☐
Herbal remedies taken?					
If yes, which ones:				Yes ☐	No ☐

Ability to relax:	Good ☐	Moderate ☐	Poor ☐		
Sleep patterns:	Good ☐	Poor ☐	Average no. of hours:		
Do you see natural daylight in your workplace?	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:		
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:	Other:			
Do you suffer from food allergies?	Yes ☐	No ☐			
Do you smoke?	Yes ☐	No ☐	How many per day:		
Do you drink alcohol?	Yes ☐	No ☐	How many units per day:		
Do you exercise?	None ☐	Occasional ☐	Irregular ☐	Regular ☐	

	Type:						
What is your skin type?	Dry	☐	Oily	☐	Combination	☐	Dehydrated ☐
Do you suffer/ have you suffered from:	Dermatitis	☐	Acne	☐	Eczema	☐	Psoriasis ☐
	Allergies	☐	Hay fever	☐	Asthma	☐	Skin cancer ☐
Stress level: 1–10 (10 being the highest)	At work:		At home:				

Massage strategy/application of a range of complex massage techniques:

Rationale for chosen massage strategies:

Protocols to follow for the chosen complex massage techniques:

Tissue response throughout the treatment:

Client feedback throughout the treatment:

Home care/aftercare advice given:

Evaluation of the purpose and benefits of each aftercare method given:

Evaluation of the effectiveness of the treatment:

Adapt treatment plans based on the evaluation of the treatment:

Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	03/09/2019	First published	Qualifications and Regulation Co-ordinator