# Client Consultation Form

**iUBT296 –** Indian head massage

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|---|---|
| **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 requiring 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):* | | | | | |
|---|---|---|---|---|---|
| Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) | ☐ | Haemophilia | ☐ | Any condition already being treated by a GP or another complementary practitioner | ☐ |
| Medical oedema | ☐ | Osteoporosis | ☐ | Arthritis | ☐ |
| Nervous/psychotic conditions | ☐ | Epilepsy | ☐ | Recent operations | ☐ |
| Diabetes | ☐ | Asthma | ☐ | Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease) | ☐ |
| Trapped/pinched nerve (e.g. sciatica) | ☐ | Inflamed nerve | ☐ | Cancer | ☐ |
| Inflamed nerve | ☐ | Cancer | ☐ | Postural deformities | ☐ |
| Postural deformities | ☐ | Spastic conditions | ☐ | Whiplash | ☐ |
| Slipped disc | ☐ | Undiagnosed pain | ☐ | When taking prescribed medication | ☐ |
| Acute rheumatism | ☐ | | | | |

| **Contra-indications that restrict treatment –** *(Select if/where appropriate):* | | | | | |
|---|---|---|---|---|---|
| Fever | ☐ | Contagious or infectious diseases | ☐ | Under the influence of recreational drugs or alcohol | ☐ |
| Diarrhoea and vomiting | ☐ | Pediculosis capitis (head lice) | ☐ | Conjunctivitis | ☐ |
| Sycosis barbae | ☐ | Skin diseases | ☐ | Undiagnosed lumps and bumps | ☐ |
| Localised swelling | ☐ | Cuts | ☐ | Bruises | ☐ |
| Abrasions | ☐ | Myalgic encephalomyelitis (Chronic fatigue syndrome) | ☐ | Psoriasis | ☐ |
| Scar tissues(2 years for major operation and 6 months for a small scar) | ☐ | Sunburn | ☐ | Hormonal implants | ☐ |
| Recent fractures (minimum 3 months) | ☐ | Cervical spondylitis | ☐ | After a heavy meal | ☐ |
| Anaphylaxis | ☐ | Vertigo | ☐ | Adhesive capsulitis | ☐ |
| Bell's palsy | ☐ | Tinnitus | ☐ | Migraine | ☐ |
| Earache | ☐ | Headaches | ☐ | | |

| **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: | |
| 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. 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 ☐ | |
| Food bingeing | Yes ☐ | | No ☐ | |
| Overeating | 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 ☐ |
| | Types | | | |
| What is your skin type? | Dry ☐ | Oil ☐ | Combination ☐ | |
| | Sensitive ☐ | 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: | |

| **Treatment details:** |
|---|
| |

| **Client feedback:** |
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| |

| Aftercare/Home care advice given: |
| --- |
| |

**Therapist/Learner signature**: _____

**Client signature**: _____

**Date of treatment**: _____

## **iUBT295 –** Follow-up Sheet

| **Details of how the therapist conducted the treatment:** |
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| |

| **Details of how the client felt during and after the treatment:** |
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| **Details of home care advice given:** |
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| |

| **Overall conclusion of the case study including reflective practice:** |
| --- |
| |

**Date of treatment**: _____

**Document History**

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