Client Consultation Form

iUBT337 – Stone therapy 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 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):*					
Pregnancy	☐	Cardiovascular conditions (thrombosis, phlebitis, hypertension, 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 dysfunctions 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	☐
Conditions causing muscular spasticity (e.g. cerebral palsy)	☐	Kidney infections	☐	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/or vomiting	☐	Skin diseases	☐	Undiagnosed lumps and bumps	☐
Localised swelling	☐	Inflammation	☐	Varicose veins	☐
Pregnancy (abdomen)	☐	Cuts	☐	Bruises	☐
Conditions affecting the neck	☐	Abrasions	☐	Scar tissue (2 years for major operation and 6 months for small scar)	☐
Sunburn	☐	Hormonal implants	☐	Menstruation - abdomen (first few days depending how the client feels)	☐
Haematoma	☐	Hernia	☐	Recent fractures (minimum 3 months)	☐
Cervical spondylitis	☐	Gastric ulcers	☐	After a heavy meal	☐
Metal pins/plates	☐	Piercings	☐		

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:				
Herbal remedies taken:				

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 ☐

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:	Others:

Do you suffer from food allergies?	Yes ☐				No ☐			
Bingeing?	Yes ☐				No ☐			
Overeating?	Yes ☐				No ☐			
Do you smoke?	No ☐		Yes ☐		How many per day?			
Do you drink alcohol?	No ☐		Yes ☐		How many units per day?			
Do your exercise?	None ☐	Occasional ☐	Irregular ☐	Regular ☐				
	Types							
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 ☐				
Stress level: 1-10 (10 being the highest)	At work		At home					

Treatment details – *(To include products used):*

Client feedback:

Aftercare/home care advice given:

Therapist/learner signature: _____

Client signature: _____

iUBT337 – Follow-up Sheet

Treatment details – *(To include products used):*

Client feedback:

After/home care advice given:

Date of treatment:_____

Document History

Version	Issue Date	Changes	Role
v1	10/10/19	First published	Qualifications Administrator