Treatment Evidence Form

iUBT364 – Provide body electrotherapy treatments

College Name:	
College 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	☐	Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Haemophilia	☐
Any condition already being treated by a GP or another practitioner	☐	Medical oedema	☐	Osteoporosis	☐
Arthritis	☐	Nervous/psychotic conditions	☐	Epilepsy	☐
Recent operations	☐	Diabetes	☐	Asthma	☐
Chemotherapy	☐	Radiotherapy	☐	Medication causing thinning/inflammation of the skin	☐
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	☐
Cervical spondylitis	☐	Conditions causing muscular spasticity (e.g. cerebral palsy)	☐	Kidney infections	☐
Whiplash	☐	Slipped disc	☐	Undiagnosed pain	☐
When taking prescribed medication	☐	Acute rheumatism	☐	Diagnosed scleroderma	☐

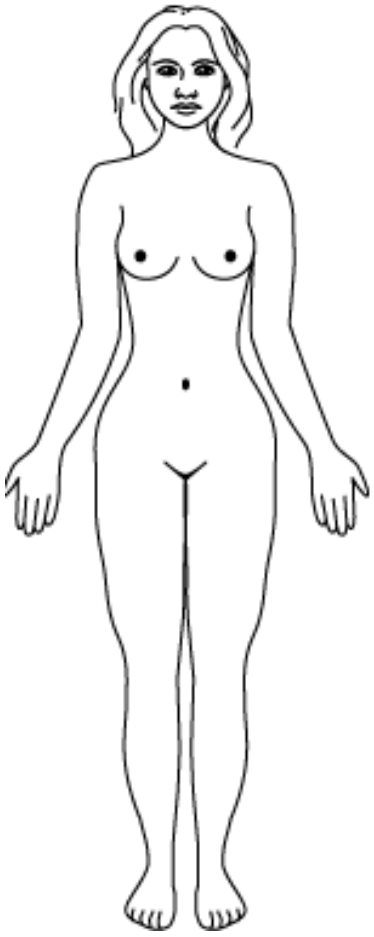
Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Bruises	☐	Hernia	☐
Contagious or infectious diseases	☐	Abrasions	☐	Recent fractures (minimum 3 months)	☐
Under the influence of recreational drugs or alcohol	☐	Scar tissue (2 years for major operation and 6 months for a small scar)	☐	Gastric ulcers	☐
Diarrhoea and vomiting	☐	Sunburn	☐	After a heavy meal	☐
Skin diseases	☐	Recent dermabrasion or chemical peels	☐	Conditions affecting the neck	☐
Varicose veins	☐	Pregnancy(abdomen)	☐	Any metal pins or plates	☐
Undiagnosed lumps and bumps	☐	Recent IPL, laser and/or epilation	☐	Loss of skin sensation (test with tactile test)	☐
Inflammation	☐	Menstruation (abdomen - first few days)	☐	IUD (coil)	☐
Cuts	☐	Haematoma	☐	Anaphylaxis	☐
Muscle fatigue	☐	Pacemaker	☐	Body piercing	☐
Hormonal implants	☐	Cervical spondylitis	☐	Loose crepey skin	☐
Excessive erythema	☐	Localised swelling	☐		

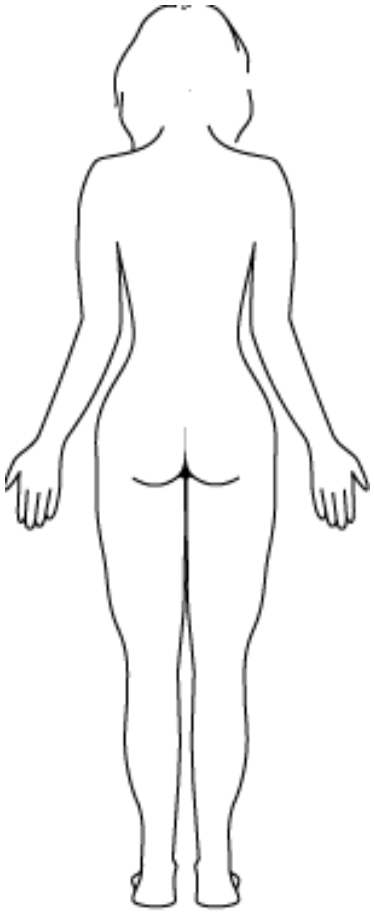
Written permission required by(either of which should be attached to the consultation form):–	
GP/specialist ☐	Informed consent ☐

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 ☐	
	Sinuses ☐	Chest ☐		
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 supplement(s)?	Yes ☐	No ☐	If so, 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: ☐		Others: ☐	
Do you suffer from food allergies?	Yes ☐		No ☐	
Bingeing?	Yes ☐		No ☐	
Overeating?	Yes ☐		No ☐	
Do you smoke?	Yes ☐	No ☐	How many a day?	
Do you drink alcohol?	Yes ☐	No ☐	How many units a day?	
Do you 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 ☐

Treatment (*Select if/where appropriate*):				
Mechanical massage ☐	Galvanism ☐	Vacuum suction ☐	Microcurrent ☐	Faradism ☐





Body analysis:					
Height:					
Weight:					
Body type/conditions:					
Postural conditions:					
Types of fat:					
Measurements:					
Upper chest (under the arms):					
Maximum chest:					
Below bust:					
Waist:					
Hips:					
Maximum buttocks (on hairline):					
Top of thigh:	R		L		
1 inch/2cm above knee	R		L		
Maximum calf muscle:	R		L		
Ankle:	R		L		
Middle of upper arm:	R		L		
Middle of lower arm:	R		L		
Wrist:	R		L		

Muscle test (select if/where appropriate):							
Quadriceps:	Excellent	☐	Good	☐	Average	☐	Poor ☐
Hamstrings:	Excellent	☐	Good	☐	Average	☐	Poor ☐
Biceps:	Excellent	☐	Good	☐	Average	☐	Poor ☐
Triceps:	Excellent	☐	Good	☐	Average	☐	Poor ☐
Abdominal:	Excellent	☐	Good	☐	Average	☐	Poor ☐
Tests							
Nerve (tactile) sensitivity test:	Yes	☐			No	☐	
Heat (thermal) sensitivity test:	Yes	☐			No	☐	

Treatment details:

Client feedback:

After/home care advice given:

Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	11/10/19	First Published	Qualifications Administrator