Client Consultation Form

iUBT411 – Spa treatments

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, 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	☐
Any dysfunction of the nervous system (e.g. Muscular 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	☐	Urinary infections	☐
Whiplash	☐	Slipped disc	☐	Undiagnosed pain	☐
When taking prescribed medication	☐	Acute rheumatism	☐		

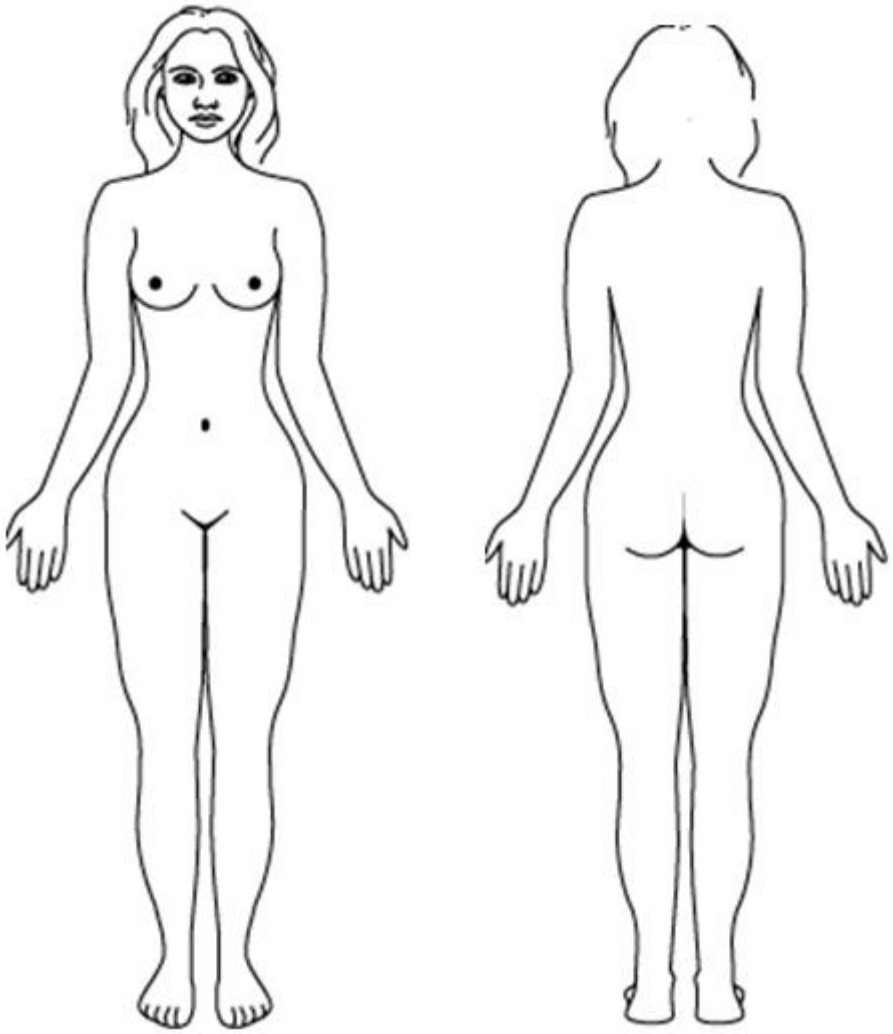
Contra-indications that restrict treatment *(select if/where appropriate):*					
Fever	☐	Contagious or infectious diseases	☐	Under the influence of recreational drugs or alcohol	☐
Diarrhoea and vomiting	☐	Skin diseases	☐	Undiagnosed lumps and bumps	☐
Localised swelling	☐	Inflammation	☐	Varicose veins	☐
Pregnancy (abdomen)	☐	Cuts	☐	Bruises	☐
Abrasions	☐	Scar tissue (2 years for major operation and 6 months for a small scar)	☐	Sunburn	☐
Hormonal implants	☐	Menstruation (first few days)	☐	Haematoma	☐
Hernia	☐	Recent fractures (minimum 3 months)	☐	Cervical spondylitis	☐
Gastric ulcers	☐	After a heavy meal	☐	Conditions affecting the neck	☐

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 medication taken?	Yes ☐	No ☐	If yes, name and type of medication:	
Herbal remedies taken?	Yes ☐	No ☐	If yes, name and type of remedy:	
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, name and type of supplement(s):	
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 eating disorders?	Yes ☐	No ☐		
Bingeing?	Yes ☐	No ☐		
Overeating?	Yes ☐	No ☐		
Undereating?	Yes ☐	No ☐		
Do you smoke?	Yes ☐	No ☐	If yes, how many per day?	
Do you drink alcohol?	No ☐	Yes ☐	If yes, how many units per day?	
Do you exercise?	None ☐	Occasional ☐	Irregular ☐	Regular ☐
	Types of exercise:			
What is your skin type?	Dry ☐	Oily ☐	Combination ☐	Sensitive ☐
	Dehydrated ☐	Young ☐	Mature ☐	
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 objective:

Figure diagnosis:				
				
Height:				
Weight:				
Skin type:				
Postural conditions:				
Measurements				
Top of thigh:	Right:	Left:		
1 inch/2cm above knee:	Right:	Left:		
Maximum calf muscle:	Right:	Left:		
Ankle:	Right:	Left:		
Middle of upper arm:	Right:	Left:		
Middle of lower arm:	Right:	Left:		
Wrist:	Right:	Left:		
Upper chest (under the arms):				

Maximum chest:	
Below bust:	
Waist:	
Hips:	
Maximum buttocks (on hairline):	

Tests				
Nerve sensitivity test:	Yes ☐	No ☐		
Heat sensitivity test:	Yes ☐	No ☐		
Pulse check:	Yes ☐	No ☐	Resting pulse rate:	

Treatment used (*select if/where appropriate):*			
Salt scrub ☐	Peel ☐	Body mask ☐	Flotation ☐
General body scrub ☐	Body brush ☐	Body wrap ☐	Seawater/seaweed treatment ☐
Steam/sauna ☐	Hydrotherapy treatment ☐		

Treatment details *(treatment selected, methods and products used, treatment duration):*

Client feedback:

After/home care advice given:

Therapist/learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	11/10/2019	First published	Qualifications Administrator