Treatment Evidence Form

iUSP151 – Conducting subjective and objective assessment

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

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

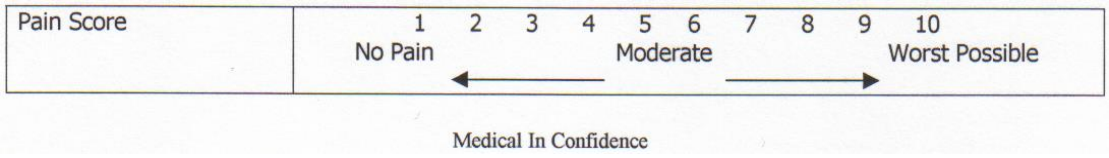
Personal details:						
Age group:	Under 20 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Lifestyle:	Active ☐			Sedentary ☐		
Last visit to the doctor:						
GP address:						
Number of children: *(If applicable)*						
Date of last period: *(If applicable)*						

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 ☐	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 ☐	Any dysfunction of the nervous system (e.g., Muscular sclerosis, Parkinson's disease, Motor neurone disease) ☐	Kidney infections ☐
Medical oedema ☐	Bell's palsy ☐	Whiplash ☐
Osteoporosis ☐	Trapped/Pinched nerve (e.g., sciatica) ☐	Slipped disc ☐
Arthritis ☐	Inflamed nerve ☐	Undiagnosed pain ☐
When taking prescribed medication ☐	Acute rheumatism ☐	Nervous/psychotic conditions ☐

Contra-indications that restrict treatment *(Select if/where appropriate):*		
Fever ☐	Varicose veins ☐	Sunburn ☐
Contagious or infectious diseases ☐	Pregnancy (abdomen) ☐	Hormonal implants ☐
Under the influence of recreational drugs or alcohol ☐	Cuts ☐	Abdomen (first few days of menstruation depending how the client feels) ☐
Diarrhoea and vomiting ☐	Bruises ☐	Haematoma ☐
Skin diseases ☐	Varicose veins ☐	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 ☐
Gastric ulcers ☐	After a heavy meal ☐	Inflammation ☐

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

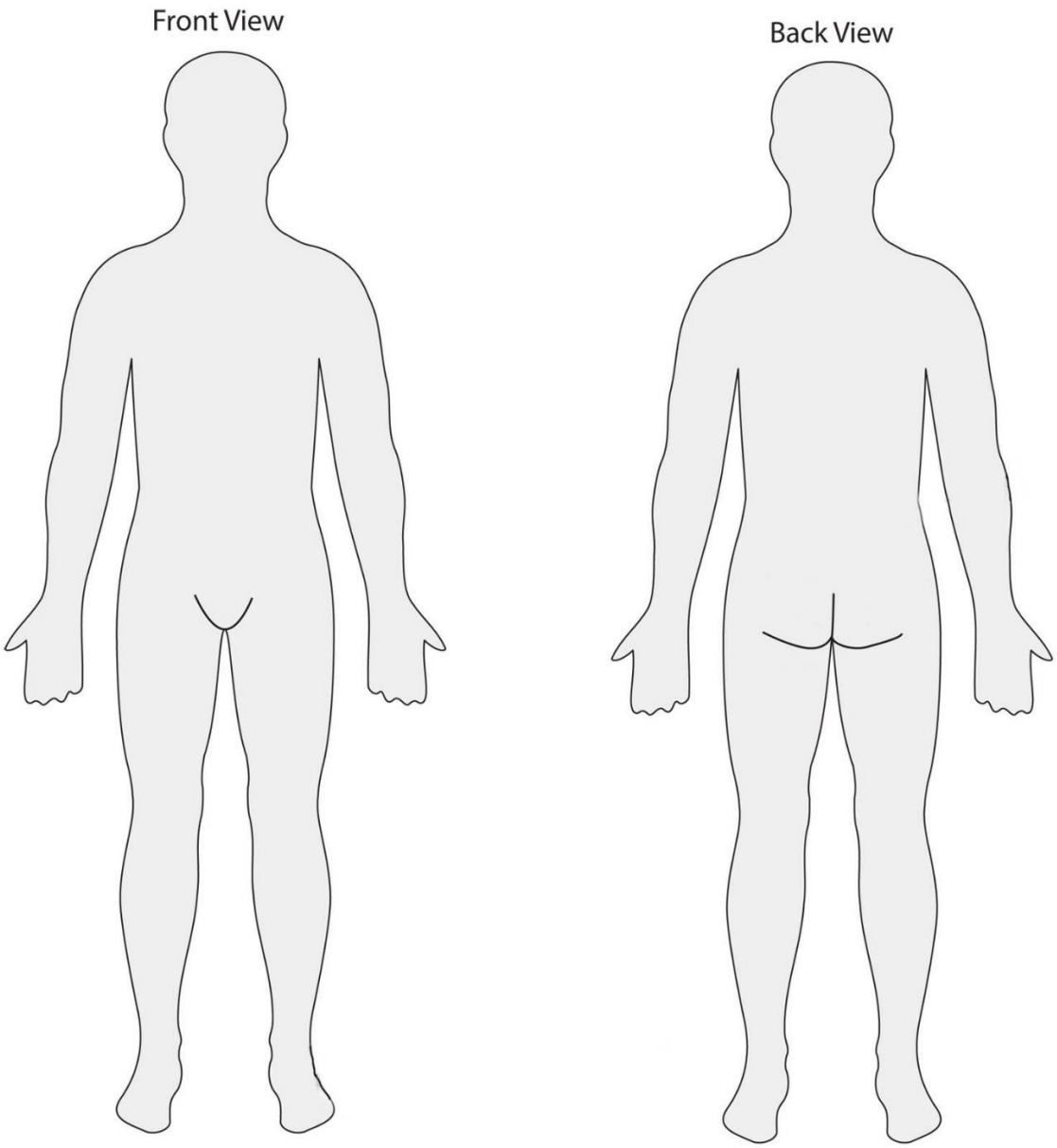
Personal information *(Select if/where appropriate):*				
Muscular/skeletal problems:	Back ☐	Aches/pain ☐	Stiff joints ☐	Headaches ☐
Digestive problems:	Constipation ☐	Bloating ☐	Liver/gall bladder ☐	Stomach ☐
Circulation:	Heart ☐	Blood pressure ☐	Fluid retention ☐	Tired legs ☐
	Varicose veins ☐	Cellulite ☐	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 ☐	
Current medical condition/ Treatment	Pain nature onset ☐	Duration ☐	Daily pain pattern:	
	Aggravates sitting ☐	Standing ☐	Walking ☐	Running ☐



History of present condition (select if/where appropriate):			
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?	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 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 ☐				
Stress level 1–10 (10 being the highest):	At work ☐		At home ☐					

Physical examination:	
Observations:	
Head:	
Shoulders:	
Back:	

Pelvis:	
Legs:	
Feet:	
Body alignment/ posture:	
	

Assessment:

To include:

Palpations:

Joint movement tested: to include spinal range and movement of the upper and lower limbs					
Joint/active/passive ROM	Right	Left	Joint Active / Passive ROM	Right	Left

Muscle tests – Isometric strength testing:		
Muscle group	Right	Left
Muscle length tests		
Muscle bulk		

Special tests:			
Test	Right	Left	Comments

Functional tests:

Range of movement findings, identifying strengths and areas for improvement:

Pre-existing conditions/disease processes (therapeutic and remedial):

Devise treatment plan and state rationale for chosen massage interventions:

Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	27/09/2019	First published	Qualifications Administrator