Treatment Evidence Form

iUBT343 – Head 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	☐	Recent operations	☐	Spastic conditions	☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Diabetes	☐	Kidney infections	☐
Haemophilia	☐	Asthma	☐	Whiplash	☐
Any condition already being treated by a GP or another complementary practitioner	☐	Any dysfunction of the nervous system (e.g. multiple sclerosis, Parkinson's disease, motor neurone disease)	☐	Slipped disc	☐
Medical oedema	☐	Bell's palsy	☐	Undiagnosed pain	☐
Osteoporosis	☐	Trapped/pinched nerve (e.g. sciatica)	☐	When taking prescribed medication	☐
Arthritis	☐	Inflamed nerve	☐	Acute rheumatism	☐
Nervous/psychotic conditions	☐	Cancer	☐	Postural deformities	☐
Epilepsy	☐				

Contra-indications that restrict treatment – *(select if/where appropriate):*					
Fever	☐	Localised swelling	☐	Sunburn	☐
Contagious or infectious diseases	☐	Inflammation	☐	Hormonal implants	☐
Under the influence of recreational drugs or alcohol	☐	Cuts	☐	Haematoma	☐
Diarrhoea and vomiting	☐	Bruises	☐	Recent fractures (minimum of three months)	☐
Skin diseases	☐	Abrasions	☐	Cervical spondylitis	☐
Undiagnosed lumps and bumps	☐	Scar tissue (2 years for major operation and 6 months for small scar)	☐	After a heavy meal	☐

Written permission required by – *either of which should be attached to the treatment form (select if/where appropriate):*			
GP/specialist	☐	Informed consent	☐

Skin test – *(select if/where appropriate):*				
Muscular/skeletal problems	Back ☐	Aches/pain ☐	Stiff joints ☐	Headaches ☐
Digestive problem	Constipation ☐	Bloating ☐	Liver/gallbladder ☐	
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 throat ☐	Colds ☐	Chest ☐
	Sinuses ☐			
Regular antibiotic/ medication	Yes ☐	No ☐	If yes, please list:	
Herbal remedies	Yes ☐		No ☐	
	If yes, please list:			
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 ☐	How many hours per day?	
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 sources:	
	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 ☐	
Do you suffer from eating disorders?	Bingeing ☐	Over eating ☐	Under eating ☐	Other ☐
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 ☐	Oily ☐	Combination ☐	Mature ☐
	Young ☐			
Do you suffer/have you suffered from	Dermatitis ☐	Acne ☐	Eczema ☐	Psoriasis ☐
	Allergies ☐	Hay fever ☐	Asthma ☐	Skin cancer ☐
Stress level from 1–10 (10 being the highest)	At work:		At home:	

Condition of the hair and scalp:

Basic treatment plan detailing area(s) massaged:

Client feedback:

Basic home/aftercare advice:

Therapist/learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	17/12/2019	First published	Qualifications Administrator