

Client Consultation Form

iUBT372 – Lymphatic drainage massage

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

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

Personal details:									
Age group:	Under 20 <input type="checkbox"/>	20 – 30 <input type="checkbox"/>	30 – 40 <input type="checkbox"/>	40 – 50 <input type="checkbox"/>	50 – 60 <input type="checkbox"/>	60+ <input type="checkbox"/>			
Lifestyle:	Active <input type="checkbox"/>			Sedentary <input type="checkbox"/>					
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 <input type="checkbox"/>	Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) <input type="checkbox"/>	Hernia <input type="checkbox"/>
Any condition already being treated by a GP or another complementary practitioner <input type="checkbox"/>	Medical oedema <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>
Arthritis <input type="checkbox"/>	Nervous/psychotic conditions <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Recent operations <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Asthma <input type="checkbox"/>
Any dysfunctions of the nervous system (e.g. multiple sclerosis, Parkinson's disease, motor neurone disease) <input type="checkbox"/>	Bell's palsy <input type="checkbox"/>	Trapped/pinched nerve (e.g. sciatica) <input type="checkbox"/>
Inflamed nerve <input type="checkbox"/>	Cancer <input type="checkbox"/>	Postural deformities <input type="checkbox"/>
Conditions causing muscular spasticity e.g. cerebral palsy <input type="checkbox"/>	Gastric ulcer <input type="checkbox"/>	Whiplash <input type="checkbox"/>
Slipped disc <input type="checkbox"/>	Acute rheumatism <input type="checkbox"/>	When taking prescribed medication <input type="checkbox"/>

Contra-indications that restrict treatment – (Select if/where appropriate):

Varicose veins <input type="checkbox"/>	Bruises <input type="checkbox"/>	Abrasions <input type="checkbox"/>
Cuts <input type="checkbox"/>	Sunburn <input type="checkbox"/>	Skin diseases <input type="checkbox"/>
Hormonal implants <input type="checkbox"/>	Recent fractures (minimum of 3 months) <input type="checkbox"/>	After a heavy meal <input type="checkbox"/>
Menstruation – abdomen (first few days) <input type="checkbox"/>		

Contra-indications that prevent treatment – (Select if/where appropriate):

Fever <input type="checkbox"/>	Contagious or infectious diseases <input type="checkbox"/>	Under the influence of recreational drugs or alcohol <input type="checkbox"/>
Diarrhoea and/or vomiting <input type="checkbox"/>	Residual malaria <input type="checkbox"/>	Undiagnosed lumps and bumps <input type="checkbox"/>
History of Tuberculosis <input type="checkbox"/>	Cardiac insufficiency <input type="checkbox"/>	Recent thrombosis <input type="checkbox"/>
Active cancer <input type="checkbox"/>	Medical oedema <input type="checkbox"/>	Kidney infections <input type="checkbox"/>
Undiagnosed pain <input type="checkbox"/>		

Written permission required by:	
GP/Specialist <input type="checkbox"/>	Informed consent <input type="checkbox"/>
<i>Either of which should be attached to the consultation form</i>	

Personal information – (Select if/where appropriate):					
Muscular/skeletal problems:	Back <input type="checkbox"/>	Aches/pain <input type="checkbox"/>	Stiff joints <input type="checkbox"/>	Headaches <input type="checkbox"/>	
Digestive problems:	Constipation <input type="checkbox"/>	Bloating <input type="checkbox"/>	Liver/gall bladder <input type="checkbox"/>	Stomach <input type="checkbox"/>	
Circulation:	Heart <input type="checkbox"/>	Blood pressure <input type="checkbox"/>	Fluid retention <input type="checkbox"/>	Tired legs <input type="checkbox"/>	
	Varicose veins <input type="checkbox"/>	Cellulite <input type="checkbox"/>	Kidney problems <input type="checkbox"/>	Cold hands and feet <input type="checkbox"/>	
Gynaecological:	Irregular periods <input type="checkbox"/>	P.M.T <input type="checkbox"/>	Menopause <input type="checkbox"/>	H.R.T <input type="checkbox"/>	
	Pill <input type="checkbox"/>	Coil <input type="checkbox"/>	Other:		
Nervous system:	Migraine <input type="checkbox"/>	Tension <input type="checkbox"/>	Stress <input type="checkbox"/>	Depression <input type="checkbox"/>	
Immune system:	Prone to infections <input type="checkbox"/>	Sore throats <input type="checkbox"/>	Colds <input type="checkbox"/>	Chest <input type="checkbox"/>	Sinuses <input type="checkbox"/>
Regular antibiotic/medication taken:					
Herbal remedies taken:					
Ability to relax:	Good <input type="checkbox"/>	Moderate <input type="checkbox"/>	Poor <input type="checkbox"/>		
Sleep patterns	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	Average no. of hours:		
Do you see natural daylight in your workplace?	Yes <input type="checkbox"/>		No <input type="checkbox"/>		
Do you work at a computer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, how many hours?		
Do you eat regular meals?	Yes <input type="checkbox"/>		No <input type="checkbox"/>		
Do you eat in a hurry?	Yes <input type="checkbox"/>		No <input type="checkbox"/>		
Do you take any food/vitamin supplements?	Yes <input type="checkbox"/>		No <input type="checkbox"/>		
How many portions of each of these items does your diet contain per day?	Fresh fruit:	Fresh vegetables:	Protein:	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 <input type="checkbox"/>			No <input type="checkbox"/>		
Bingeing?	Yes <input type="checkbox"/>			No <input type="checkbox"/>		
Overeating?	Yes <input type="checkbox"/>			No <input type="checkbox"/>		
Do you smoke?	No <input type="checkbox"/>	Yes <input type="checkbox"/>		How many per day?		
	Other:					
Do you drink alcohol?	No <input type="checkbox"/>	Yes <input type="checkbox"/>		How many units per day?		
Do your exercise?	None <input type="checkbox"/>	Occasional <input type="checkbox"/>	Irregular <input type="checkbox"/>		Regular <input type="checkbox"/>	
	Types:					
What is your skin type?	Dry <input type="checkbox"/>	Oil <input type="checkbox"/>	Combination <input type="checkbox"/>	Sensitive <input type="checkbox"/>	Dehydrated <input type="checkbox"/>	
Do you suffer/have you suffered from?	Dermatitis <input type="checkbox"/>	Acne <input type="checkbox"/>		Eczema <input type="checkbox"/>		Psoriasis <input type="checkbox"/>
	Allergies <input type="checkbox"/>	Hay fever <input type="checkbox"/>		Asthma <input type="checkbox"/>		Skin cancer <input type="checkbox"/>
Stress level: 1-10 (10 being the highest)	At work:			At home:		

Treatment details – (to include products used):

Client feedback:

After/home care advice given:

Therapist/Learner signature: _____

Client signature: _____

Lymphatic drainage massage: 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	19/12/2019	First published	Qualifications Administrator