Treatment Evidence Form

iUBT320 – Provide body 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	☐	Diabetes	☐	Postural deformities	☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Asthma	☐	Cervical spondylitis	☐
Haemophilia	☐	Chemotherapy	☐	Conditions causing muscular spasticity (e.g. cerebral palsy)	☐
Any condition already being treated by a GP or a practitioner	☐	Radiotherapy	☐	Kidney infections	☐
Medical oedema	☐	Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease)	☐	Whiplash	☐
Osteoporosis	☐	Bell's palsy	☐	Slipped disc	☐
Arthritis	☐	Trapped/pinched nerve (e.g. sciatica)	☐	Undiagnosed pain	☐
Nervous/psychotic conditions	☐	Inflamed nerve	☐	When taking prescribed medication	☐
Epilepsy	☐	Cancer	☐	Acute rheumatism	☐
Recent operations	☐	Work related injuries (e.g. back injury, carpal tunnel syndrome, neck strain, repetitive strain injury)	☐		

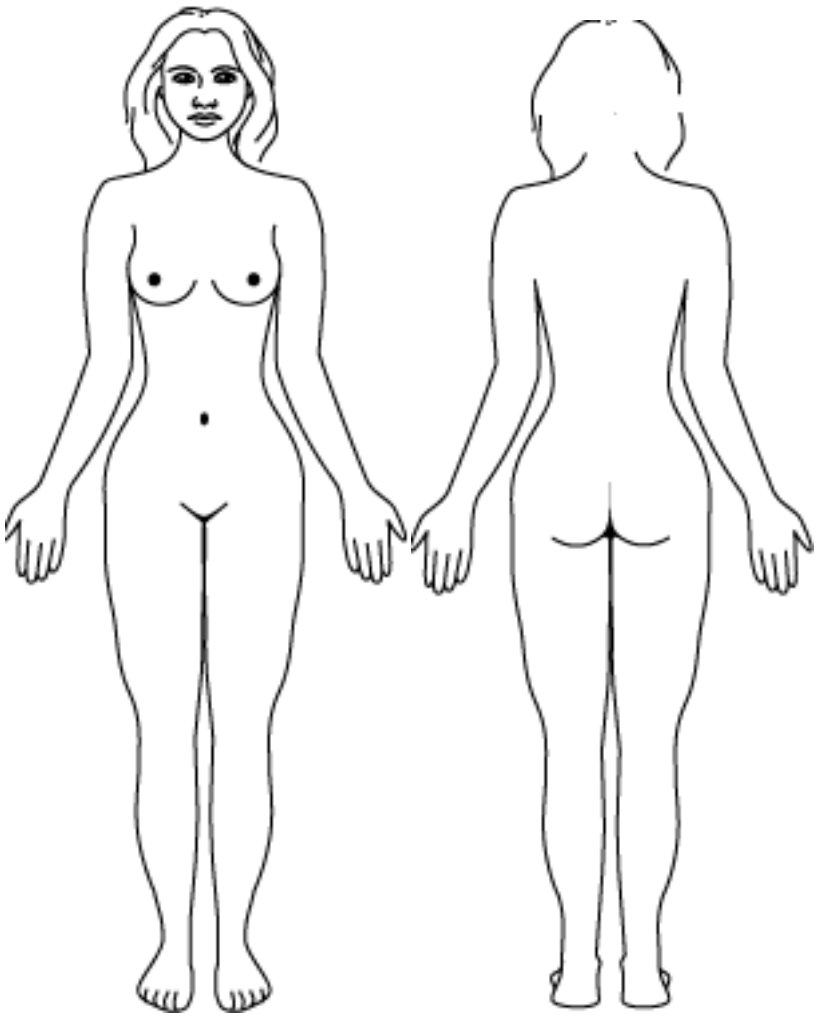
Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Bruises	☐	After a heavy meal	☐
Contagious or infectious diseases	☐	Abrasions	☐	Conditions affecting the neck	☐
Under the influence of recreational drugs or alcohol	☐	Scar tissues (2 years for major operation and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

Written permission required by – *either of which should be attached to the consultation form (Select if/where appropriate):*	
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 ☐		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 supplements?	Yes ☐	No ☐	If yes, which ones?	

How many portions of each of these 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 ☐			
Do you suffer from eating disorders?	Bingeing? ☐		Overeating? ☐		Undereating? ☐			
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 ☐		Normal ☐		Young ☐	
	Mature ☐							
Do you suffer/have suffered from:	Dermatitis ☐		Acne ☐		Eczema ☐		Psoriasis ☐	
	Allergies ☐		Hay fever ☐		Asthma ☐		Skin cancer ☐	

Treatment objective – *(Select if/where appropriate):*		
Stimulating ☐	Relaxing ☐	Anti-cellulite ☐
Invigorating ☐	Uplifting ☐	Use of infrared ☐
Soothing ☐	Sense of wellbeing ☐	

Body Analysis	
	
Height:	
Weight:	
Skin type/condition:	
Types of fat:	
Body type:	
Postural conditions:	
Muscle tone:	

Treatment details – *(To include products used):*

Client feedback:

After/home care advice given:

Therapist/Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	27/09/2019	First published	Qualifications and Regulation Co-ordinator
v2	14/01/2020	Amended consultation to treatment evidence	Qualifications and Regulation Co-ordinator