

Treatment Evidence Form

iUBT433 – Indian 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 <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):

Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) <input type="checkbox"/>	Haemophilia <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 dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease) <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"/>	Whiplash <input type="checkbox"/>
Slipped disc <input type="checkbox"/>	Undiagnosed pain <input type="checkbox"/>	When taking prescribed medication <input type="checkbox"/>
Acute rheumatism <input type="checkbox"/>		

Contra-indications that restrict 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 vomiting <input type="checkbox"/>	Pediculosis capitis (head lice) <input type="checkbox"/>	Conjunctivitis <input type="checkbox"/>
Sycosis barbae <input type="checkbox"/>	Skin diseases <input type="checkbox"/>	Undiagnosed lumps and bumps <input type="checkbox"/>
Localised swelling <input type="checkbox"/>	Inflammation <input type="checkbox"/>	Cuts <input type="checkbox"/>
Bruises <input type="checkbox"/>	Abrasions <input type="checkbox"/>	Myalgic encephalomyelitis (chronic fatigue syndrome) <input type="checkbox"/>
Psoriasis <input type="checkbox"/>	Scar tissues (2 years for major operation and 6 months for a small scar) <input type="checkbox"/>	Sunburn <input type="checkbox"/>
Hormonal implants <input type="checkbox"/>	Recent fractures (minimum 3 months) <input type="checkbox"/>	Cervical spondylitis <input type="checkbox"/>
After a heavy meal <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Vertigo <input type="checkbox"/>
Adhesive capsulitis <input type="checkbox"/>	Bell's palsy <input type="checkbox"/>	Tinnitus <input type="checkbox"/>
Migraine <input type="checkbox"/>	Earache <input type="checkbox"/>	Headaches <input type="checkbox"/>
Metal pins or plates <input type="checkbox"/>	Piercings <input type="checkbox"/>	

Written permission required by (Either of which should be attached to the consultation form.):

GP/specialist <input type="checkbox"/>	Informed consent <input type="checkbox"/>
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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?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, which ones:	
Herbal remedies taken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, which ones:	
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"/>	If yes, 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:	Other:		

Do you suffer from food allergies?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Food bingeing	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Overeating	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Do you smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many per day?	
Do you drink alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many units per day?	
Do you 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: _____

Date of treatment: _____

iUBT433 – 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	30/09/2019	First published	Qualifications and Regulation Co-ordinator
v2	14/01/2020	Amended consultation to treatment evidence	Qualifications and Regulation Co-ordinator