Client Consultation Form

iUBT370 – Figure diagnosis and body electrical treatments

iUBT348 – Swedish 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	☐	Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Haemophilia	☐
Any condition already being treated by a GP or another practitioner	☐	Medical oedema	☐	Osteoporosis	☐
Arthritis	☐	Nervous/psychotic conditions	☐	Epilepsy	☐
Recent operations	☐	Diabetes	☐	Asthma	☐
Any dysfunction of the nervous system (e.g. Muscular sclerosis, Parkinson's disease, Motor neurone disease)	☐	Bell's palsy	☐	Trapped/pinched nerve (e.g. sciatica)	☐
Inflamed nerve	☐	Cancer	☐	Postural deformities	☐
Conditions causing muscular spasticity (e.g. cerebral palsy)	☐	Kidney infections	☐	Whiplash	☐
Slipped disc	☐	Undiagnosed pain	☐	When taking prescribed medication	☐
Acute rheumatism	☐				

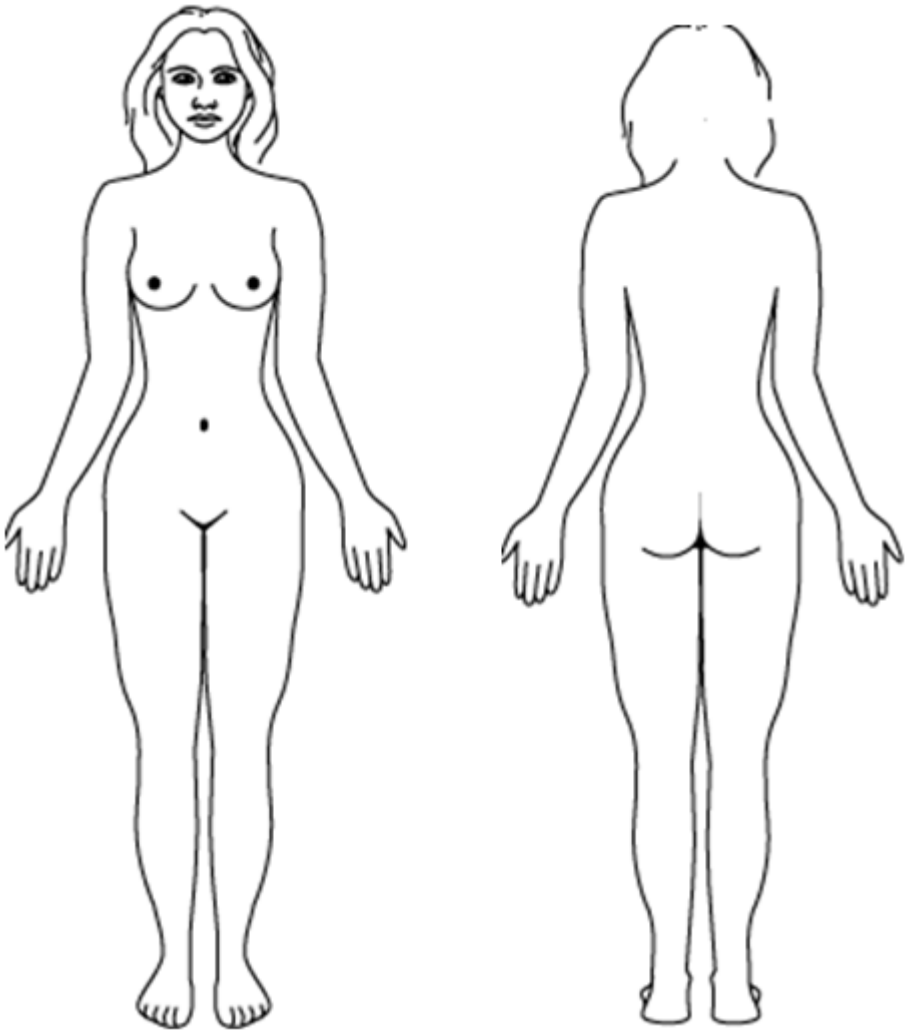
Contra-indications that restrict treatment *(Select if/where appropriate):*					
Fever	☐	Contagious or infectious diseases	☐	Under the influence of recreational drugs or alcohol	☐
Diarrhoea and vomiting	☐	Skin diseases	☐	Undiagnosed lump and bumps	☐
Localised swelling	☐	Inflammation	☐	Varicose veins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

Epilation in the treatment area ☐	Micropigmentation in the treatment area ☐	

Written permission required by:	
GP/Specialist ☐	Informed consent ☐
Either of which should be attached to the consultation form	

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 ☐	Anxiety ☐
Immune system:	Prone to infections ☐	Sore throats ☐	Colds ☐	Chest ☐	Sinuses ☐
Regular antibiotic/medication taken:					
Herbal remedies taken:					
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			

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:	Other:
Do you suffer from food allergies?	Yes			No		
Bingeing?	Yes			No		
Overeating?	Yes			No		
Do you smoke?	No		Yes		How many per day?	
Do you drink alcohol?	No		Yes		How many units per day?	
Do your 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		
Figure diagnosis:	Height:		Weight:		Body type:	
	Areas of soft fat:		Areas of cellulite:		Postural conditions:	
Measurements:	Upper chest (under the arms):		Maximum chest:		Below bust:	
	Waist:		Hips:		Maximum buttocks (on hairline):	
Top of thigh:	Right:			Left:		
1inch/2cm above knee:	Right:			Left:		
Maximum calf muscle:	Right:			Left:		
Ankle:	Right:			Left:		
Middle of upper arm:	Right:			Left:		

Middle of lower arm:	Right:		Left:	
Wrist:	Right:		Left:	
				
Muscle test (select if/where appropriate):				
Quadriceps:	Excellent	Good	Average	Poor
Hamstrings:	Excellent	Good	Average	Poor
Biceps:	Excellent	Good	Average	Poor
Triceps:	Excellent	Good	Average	Poor
Abdominal:	Excellent	Good	Average	Poor
Exercise advice:				
Tests:				
Nerve sensitivity test:	Yes		No	
Heat sensitivity test:	Yes		No	

Treatment details *(To include equipment used and products used):*

Client feedback:

After/home care advice given:

Therapist/Learner signature: _____

Client signature: _____

Body treatments: 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	21/08/2019	First published	Qualifications and Regulation Co-ordinator