Treatment Evidence Form

iUBT344 – Apply stone therapy 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	☐	Postural deformities	☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, heart conditions)	☐	Diabetes	☐	Conditions causing muscular spasticity (e.g. cerebral palsy)	☐
Haemophilia	☐	Asthma	☐	Kidney infections	☐
Any condition already being treated by a GP or another complementary practitioner	☐	Epilepsy	☐	Whiplash	☐
Medical oedema	☐	Bell's palsy	☐	Slipped disc	☐
Osteoporosis	☐	Trapped/pinched nerve (e.g. sciatica)	☐	Undiagnosed pain	☐
Arthritis	☐	Inflamed nerve	☐	When taking prescribed medication	☐
Nervous/psychotic conditions	☐	Cancer	☐	Acute rheumatism	☐
Loss of skin sensitivity	☐	Clinical obesity	☐		

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Varicose veins	☐	Abdomen (first few days of menstruation depending on how the client feels)	☐
Contagious or infectious diseases	☐	Pregnancy (abdomen)	☐	Haematoma	☐
Under the influence of recreational drugs or alcohol	☐	Cuts	☐	Hernia	☐
Diarrhoea and/or vomiting	☐	Bruises	☐	Recent fractures (minimum 3 months)	☐
Skin diseases	☐	Abrasions	☐	Cervical spondylitis	☐
Undiagnosed lumps and bumps	☐	Scar tissue (2 years for major operation and 6 months for a small scar)	☐	Gastric ulcers	☐
Localised swelling	☐	Sunburn	☐	After a heavy meal	☐
Inflammation	☐	Hormonal implants	☐	Conditions affecting the neck	☐
Areas of skin aggravated by heat	☐	Metal pins/plates	☐	Piercings	☐
During cancer treatment	☐				

Contra-indications which prevent treatment – *(Select if/where appropriate):*		
Contagious skin diseases ☐	Recent scar tissue ☐	Any dysfunction of the nervous system (e.g. Muscular sclerosis, Parkinson's disease, Motor neurone disease) ☐

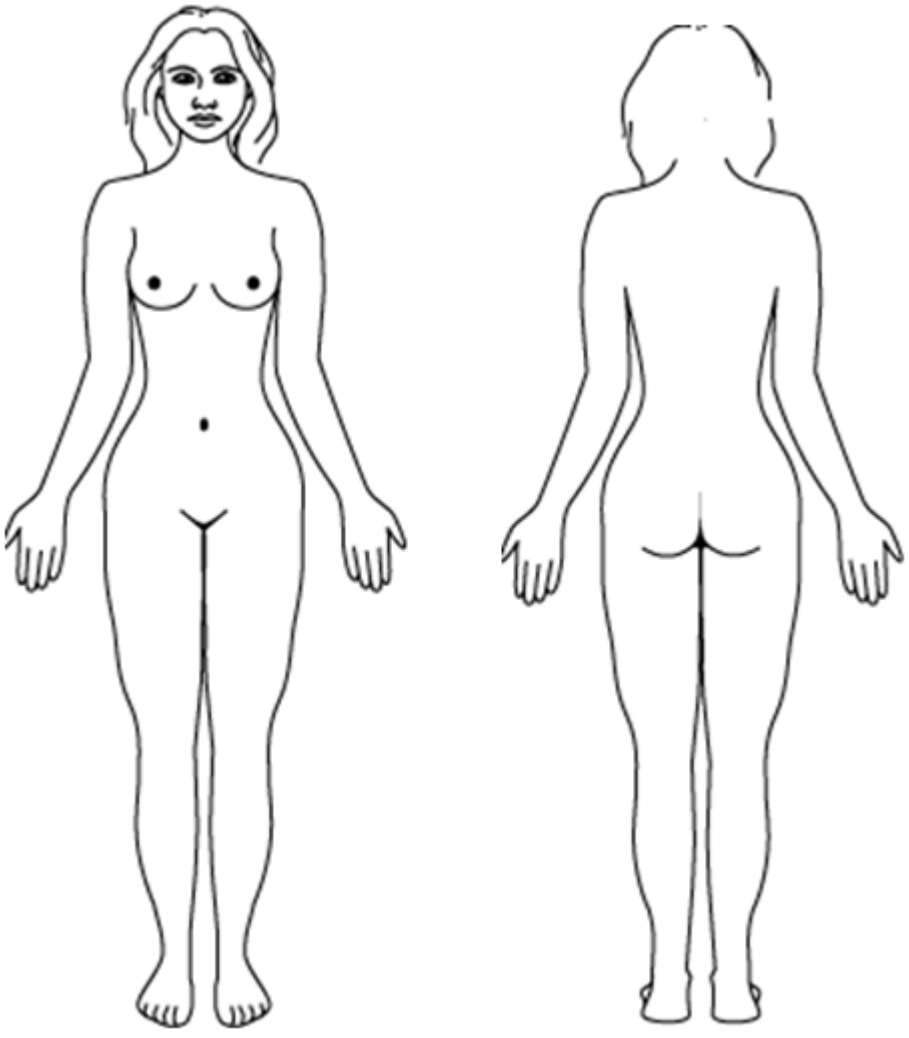
Written permission required by – *either of which should be attached to the consultation form. (Select if/where appropriate):*	
GP/Specialist ☐	Informed consent ☐

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	Fish or white meat
	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 binge eat?	Yes ☐		No ☐	
Do you overeat?	Yes ☐		No ☐	
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 ☐	Sensitive ☐
	Dehydrated ☐			
Do you suffer/have 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:
Body Mass Index		



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 aims/recommendations – *(To include details of current regime):*

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

Client feedback:

After/home care advice given:

Therapist/learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	19/11/2019	First published	Qualifications Administrator
v2	14/01/2020	Amended consultation to treatment evidence	Qualifications and Regulation Co-ordinator