Treatment Evidence Form

iUBT365 – Provide spa treatments

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

Contra-indications that restrict treatment *(select if/where appropriate):*					
Fever	☐	Varicose veins	☐	Menstruation (first few days)	☐
Contagious or infectious diseases	☐	Pregnancy (abdomen)	☐	Haematoma	☐
Under the influence of recreational drugs or alcohol	☐	Cuts	☐	Hernia	☐
Diarrhoea and vomiting	☐	Bruises	☐	Recent fractures (minimum 3 months)	☐
Skin diseases	☐	Abrasions	☐	Gastric ulcers	☐
Undiagnosed lumps and bumps	☐	Scar tissue (2 years for major operation and 6 months for a small scar)	☐	After a heavy meal	☐
Localised swelling	☐	Sunburn	☐	Conditions affecting the neck	☐
Inflammation	☐	Hormonal implants	☐	Claustrophobia	☐
Migraine	☐	Excessive erythema	☐	Body piercing	☐
Loss of skin sensation (tactile test required)	☐	Sensitive skin	☐	Recent epilation/depilation (24-48 hrs)	☐
Pacemaker	☐	Perforated eardrums	☐		

Written permission required by *(either of which should be attached to the consultation form):*	
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 ☐	
	Sinuses ☐	Chest ☐		
Regular medication taken?	Yes ☐	No ☐	If yes, name and type of medication:	
Herbal remedies taken?	Yes ☐	No ☐	If yes, name and type of remedy:	
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, name and type of supplement(s):	
How many portions of each	Fresh fruit: ☐	Fresh vegetables: ☐	Protein and source:	

of these items does your diet contain per day?	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?	Yes ☐		No ☐	
Bingeing?	Yes ☐		No ☐	
Overeating?	Yes ☐		No ☐	
Undereating?	Yes ☐		No ☐	
Do you smoke?	Yes ☐	No ☐	How many a day?	
Do you drink alcohol?	Yes ☐	No ☐	How many units a day?	
Do you exercise?	None ☐	Occasional ☐	Irregular ☐	Regular ☐
	Types of exercise:			
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 ☐	

Treatment objective:

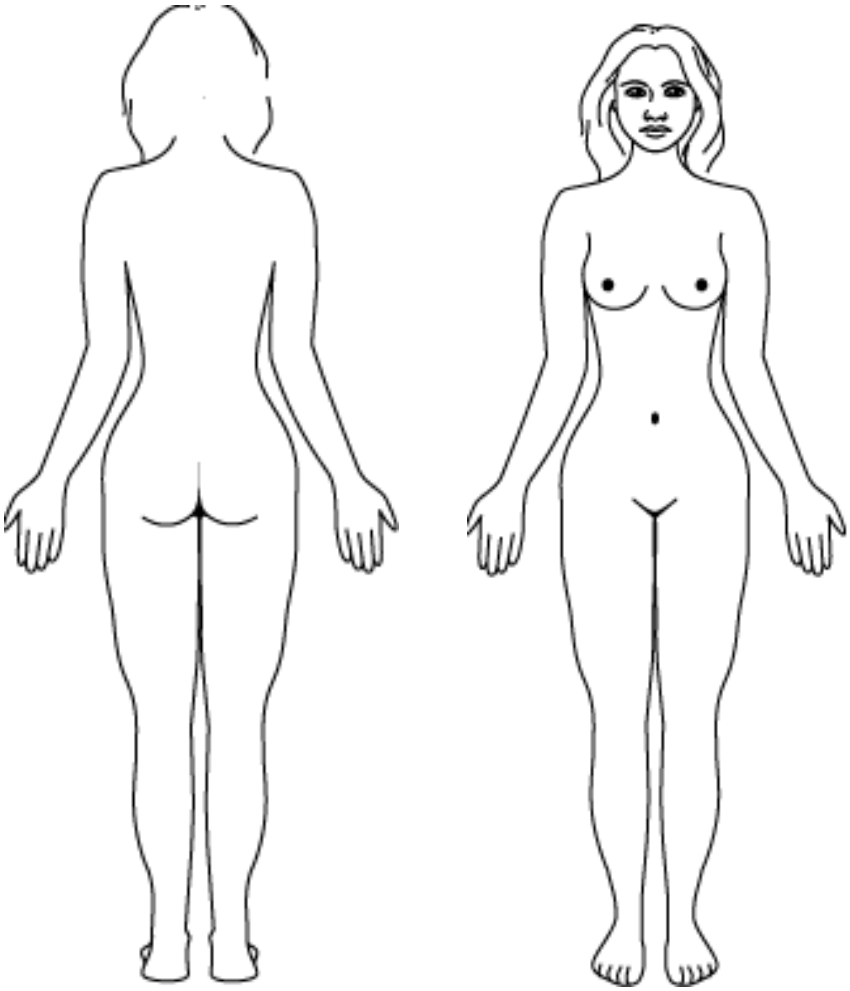

Figure diagnosis:	
Height:	
Weight:	
Skin type:	
Postural conditions:	

Measurements:				
Top of thigh:	Right:		Left:	
1 inch/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:	
Upper chest(under the arms):				
Maximum chest:				
Below bust:				
Waist:				
Hips:				
Maximum buttocks (on hairline):				

Tests:					
Nerve sensitivity test:	Yes ☐			No ☐	
Heat sensitivity test:	Yes ☐			No ☐	
Pulse check:	Yes ☐	No ☐		Resting pulse rate:	

Treatment used *(select if/where appropriate):*		
Salt scrub ☐	Peel ☐	Body mask ☐
Flotation ☐	General body scrub ☐	Body brush ☐
Body wrap ☐	Seawater/seaweed treatment ☐	

Treatment details *(treatment selected, methods and products used, treatment duration):*

Client feedback:

After/home care advice given:

Therapist/Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	11/10/19	First published	Qualification Administrator
v2	14/01/2020	Amended consultation to treatment evidence	Qualifications and Regulation Co-ordinator