Client Treatment Evidence Form

iUSP157 – Provide sports massage techniques to prevent and manage injury

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)*						

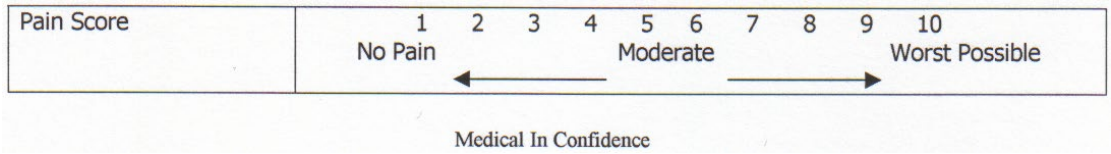
Contra-indications requiring medical permission – *(Select if/where appropriate):*					
Pregnancy	☐	Recent operations	☐	Postural deformities	☐
Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Diabetes	☐	Spastic conditions	☐
Haemophilia	☐	Asthma	☐	Kidney infections	☐
Any condition already being treated by a GP or another health professional, e.g., Physiotherapist, Osteopath, Chiropractor, Coach	☐	Any dysfunction of the nervous system (e.g., Muscular sclerosis, Parkinson's disease, Motor neurone disease)	☐	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	☐
Epilepsy	☐				

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Varicose veins	☐	Abdomen (first few days of menstruation depending how the client feels)	☐
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	☐	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	☐		

Written permission required by GP/Specialist – *which should be attached to the consultation form:*			
Yes	☐	No	☐

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:	
	Are you pregnant or trying for a baby?		Yes ☐	No ☐
Nervous system:	Migraine ☐	Tension ☐	Stress ☐	Depression ☐
Immune system:	Prone to infections ☐	Sore throats ☐	Colds ☐	Chest ☐
	Sinuses ☐			

Current medical condition/treatment				
Pain nature	Onset ☐	Duration ☐	Daily pain pattern:	
Aggravates	Sitting ☐	Standing ☐	Walking ☐	Running ☐
Eases	Sitting ☐	Standing ☐	Walking ☐	Running ☐



History of present condition				
Recurring injury	Yes ☐		No ☐	
What treatment was undertaken?				
How long did the injury take to heal?				
Eases	Sitting ☐	Standing ☐	Walking ☐	Running ☐

Did you have any investigations?		
If yes, which ones:	Yes ☐	No ☐
Regular antibiotic/medication taken?		
If yes, which ones:	Yes ☐	No ☐

Herbal remedies taken?								
If yes, which ones:							Yes ☐	No ☐
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 items does your diet contain per day?	Fresh fruit		Fresh vegetables		Protein		Source?	
	Dairy produce		Sweet things		Added salt		Added suger	
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 smoke?	No ☐		Yes ☐		How many per day?			
Do you drink alcohol?	No ☐		Yes ☐		How many units per day?			
Do you exercise?	None ☐		Occasional ☐		Irregular ☐		Regular ☐	
	Type:							
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:			

Massage strategy/application of a range of soft tissue techniques:

Injury management:

Injury prevention:

Tissue response throughout the treatment:

Client feedback throughout the treatment:

Home care/aftercare advice given:

Evaluation of the effectiveness of the treatment:

Adapt treatment plans based on the evaluation of the treatment:

Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	07/02/2020	First published	Qualifications Administrator