Treatment Evidence Form

iUCT43 – Provide massage using pre-blended aromatherapy oils

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

Contra-indications that restrict treatment *(Select if/where appropriate):*					
Fever	☐	Cuts	☐	Abdomen (first few days of menstruation)	☐
Contagious or infectious diseases	☐	Bruises	☐	Haematoma	☐
Under the influence of recreational drugs or alcohol	☐	Abrasions	☐	Recent fractures (minimum 3 months)	☐
Diarrhoea and/or vomiting	☐	Scar tissue (2 years for major operation and 6 months for a small scar)	☐	Gastric ulcers	☐
Skin diseases	☐	Varicose veins	☐	Hernia	☐
Undiagnosed lumps and bumps	☐	Pregnancy (abdomen)	☐	Sunburn	☐
Localised swelling	☐	Breast feeding	☐	After a heavy meal	☐
Inflammation		Cervical spondylitis	☐	Anaphylaxis	☐
Body piercing		Hypersensitive skin	☐		

- N.B. All known allergies should be checked

Client contra-indications should be checked against the safety data

Evidence of patch test:	
Yes ☐	No ☐
Comments:	

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 ☐
	Other:			
Digestive problems:	Constipation ☐	Bloating ☐	Liver/Gall bladder ☐	Stomach ☐
	Other:			
Circulation:	Heart ☐	Blood pressure ☐	Fluid retention ☐	Tired legs ☐
	Varicose veins ☐	Cellulite ☐	Kidney problems ☐	Cold hands and feet ☐
Gynaecological:	Irregular periods ☐	P.M.T ☐	Menopause ☐	
	Pill ☐	Coil ☐	H.R.T ☐	
	Other:			
Nervous system:	Migraine ☐	Tension ☐	Stress ☐	Depression ☐
	Other:			
Immune system:	Prone to infections ☐	Sore throats ☐	Colds ☐	
	Sinuses ☐	Chest ☐		
	Other:			
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 so, 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:		Others:						
Do you suffer from food allergies?	Yes ☐					No ☐			
Bingeing?	Yes ☐					No ☐			
Overeating?	Yes ☐					No ☐			
Do you smoke?	Yes ☐		No ☐			How many a day?			
	Other:								
Do you drink alcohol?	Yes ☐		No ☐			How many units a day?			
Do you 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			

Client feedback:

Treatment details (to include reason for treatment and justification for choice of blended oil):

After/home care advice given:

Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v0.7	12/11/2019	Amended as outlined by comments	Systems Integration Team
v1.0	09/12/2019	Published	Qualifications Administrator
v.2.0	04/07/2023	Amended page 4, added ‘other’ section for smoking. Removed draft comment.	Qualifications Administrator