Client Consultation Form

iUSP178 – Sports massage 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)*	

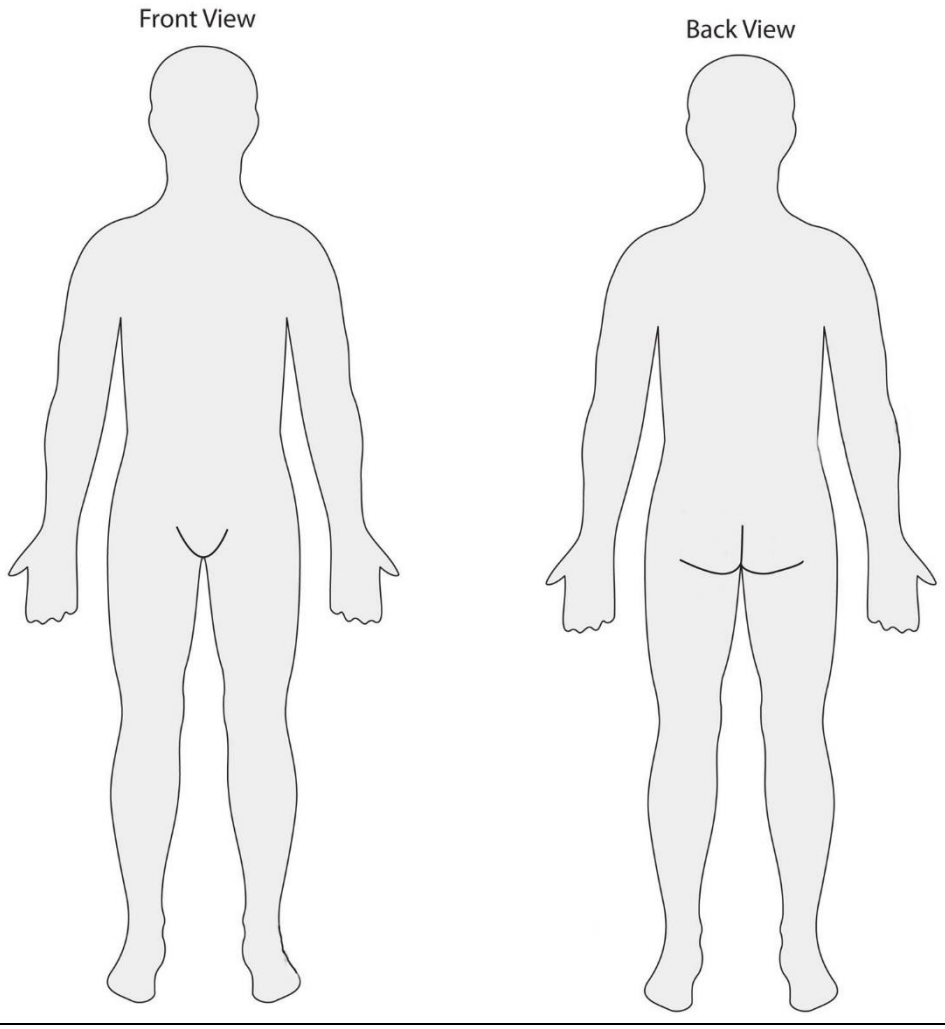
Contra-indications requiring medical permission *(Select if/where appropriate):*					
Pregnancy	☐	Acute trauma	☐	Postural deformities	☐
Thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Open wounds	☐	Spastic conditions	☐
Haemophilia	☐	Acute soft tissue injury	☐	Kidney infections	☐
Any condition already being treated by a GP or another health professional, e.g., physiotherapist, osteopath, chiropractor, coach	☐	Periostitis	☐	Whiplash	☐
Medical oedema	☐	Risk of haemorrhage	☐	Slipped disc	☐
Osteoporosis	☐	Asthma	☐	Undiagnosed pain	☐
Arthritis	☐	Any dysfunction of the nervous system (e.g., multiple sclerosis, Parkinson's disease, motor neurone disease)	☐	When taking prescribed medication	☐
Nervous/psychotic conditions	☐	Bell's palsy	☐	Acute rheumatism	☐
Epilepsy	☐	Trapped/pinched nerve (e.g., sciatica)	☐	Tumour	☐
Recent operations	☐	Inflamed nerve	☐	Frostbite	☐
Diabetes	☐	Cancer	☐	Bursitis	☐
Myositis ossificans	☐	Mental incapacity	☐		

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 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?	
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 ☐	

Physical examination *(Select if/where appropriate):*	
Head:	

Shoulders:	
Back:	
Pelvis:	
Legs:	
Feet:	
Body alignment/ posture:	
	

Reason for sports massage treatment plan including pre-event, post-event and maintenance:

Client feedback:

Reflect on feedback received and self-analysis of treatment:

Home care/aftercare advice:

Therapist/learner signature: _____

Client signature: _____

Date: _____