Client Consultation Form

Body Treatments

2022 version 1.0

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| **Student name** | Click or tap here to enter text. | **ID #** | Enter text. |

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| **Client Information** | | | | | |
| **Client name** | Click or tap here to enter text. | | | **Cell #** | Enter text. |
| **Client address** | Click or tap here to enter text. | | | | |
| **Profession** | Click or tap here to enter text. | | | | |
| **Treatment date** | Enter date. | **Home #** | Enter text. | **Work #** | Enter text. |

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| **Personal details** | | | | | | | | | |
| **Age group** | Choose age group. | | **Lifestyle** | | Active |  | Sedentary | |  |
| **Last GP visit** | Click or tap to enter a date. | | | | | | | | |
| **GP name** | Click or tap here to enter text. | | | | | | | | |
| **GP address** | Click or tap here to enter text. | | | | | | | | |
| **No of children** | Choose an item. | *If applicable* | | **Last period** | Enter text. | | | *If applicable* | |

# Contraindications

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| **Contraindications requiring medical permission** – *where medical permission cannot be obtained, clients must give their informed consent in prior to treatment. Select if / when appropriate:* | | | | | |
| Pregnancy |  | Cardiovascular conditions[[1]](#footnote-1) |  | Haemophilia |  |
| Any condition being treated by a GP or another practitioner |  | Medical oedema |  | Osteoporosis |  |
| Arthritis |  | Nervous / psychotic conditions |  | Epilepsy |  |
| Recent operations |  | Diabetes |  | Asthma |  |
| Any dysfunction of the nervous system[[2]](#footnote-2) |  | Bell’s palsy |  | Trapped / pinched nerve |  |
| Inflamed nerve |  | Cancer |  | Postural deformities |  |
| Spastic conditions |  | Kidney infections |  | Whiplash |  |
| Slipped disc |  | Undiagnosed pain |  | When taking prescribed medication |  |
| Acute rheumatism |  |  |  |  |  |

| **Contraindications that restrict treatment** –*Select if / when appropriate:* | | | | | |
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| Fever |  | Contagious or infectious diseases |  | Under the influence of recreational drugs or alcohol |  |
| Diarrhoea and vomiting |  | Skin diseases |  | Undiagnosed lumps and bumps |  |
| Localised swelling |  | Inflammation |  | Varicose veins |  |
| Pregnancy (abdomen) |  | Cuts |  | Bruises |  |
| Abdomen (first few days of menstruation, depending on how client feels) |  | Scar tissue (2 years for major operation and 6 months for small scar) |  | Recent fractures (minimum 3 months) |  |
| Hormonal implants |  | Abrasions |  | Haematoma |  |
| Hernia |  | Sunburn |  | Cervical spondylitis |  |
| Gastric ulcers |  | After a heavy meal |  | Anaphylaxis |  |
| Body piercing |  | Recent injuries |  | Conditions affecting the neck |  |

# Personal Information

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| **Anatomical and physiological problems** – *Select if / when appropriate* | | | | | | | | |
| Muscular / skeletal | Back |  | Aches / pain |  | Stiff joints |  | Headaches |  |
| Digestive | 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 |  | PMT |  | Menopause |  | HRT |  |
| Pill |  | Coil |  | Other | Enter text | | |
| Nervous system | Migraine |  | Tension |  | Stress |  | Depression |  |
| Immune system | Prone to infections |  | Sore throats |  | Colds |  | Chest |  |
| Sinuses |  |  |  |  |  |  |  |

| **Further assorted personal information** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Further assorted personal information | Click or tap here to enter text. | | | | | | | |
| Regular antibiotics / medication taken | Click or tap here to enter text. | | | | | | | |
| Herbal remedies taken | Click or tap here to enter text. | | | | | | | |
| Ability to relax | Good |  | Moderate |  | Poor |  |  |  |
| Sleep patterns | Good |  | Poor |  | Average hours of sleep | | | Choose |
| Do you see natural light at your workplace? | | | | | Yes |  | No |  |
| Do you work at a computer? | | | | | Yes |  | No |  |

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| **About your nutritional intake** | | | | | | | | | | | |
| Do you eat regular meals? | | | | | | | Yes |  | | No |  |
| Do you eat in a hurry? | | | | | | | Yes |  | | No |  |
| Do you eat any food / vitamin supplements? | | | | | | | Yes |  | | No |  |
| How many portions of each of these items does your diet contain per day? | | | | | | | | | | | |
| Fresh fruit | Choose an item. | | | | Fresh vegetables | | | | Choose an item. | | |
| Protein | Choose an item. | | | | Source of protein? | | | | Enter text. | | |
| Carbohydrates | Choose an item. | | | | Sources of carbs? | | | | Enter text. | | |
| Sweet things | Choose an item. | | | | Dairy produce | | | | Choose an item. | | |
| Added salt | Choose an item. | | | | Added sugar | | | | Choose an item. | | |
| How many units of these drinks do you consume per day? | | | | | | | | | | | |
| Tea | Choose an item. | | | | Coffee | | | | Choose an item. | | |
| Fruit juice | Choose an item. | | | | Water | | | | Choose an item. | | |
| Soft drinks | Choose an item. | | | | Others | | | | Choose an item. | | |
| Do you suffer from food allergies? | | | | | | | Yes |  | | No |  |
| Do you suffer from binge eating? | | | | | | | Yes |  | | No |  |
| Do you suffer from over-eating? | | | | | | | Yes |  | | No |  |
| Do you smoke? | | No |  | Yes | |  | How many per day? | | | | Choose |
| Do you drink alcohol? | | No |  | Yes | |  | How many per day? | | | | Choose |

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| **Further health information** | | | | | | | | | | | | | | |
| How often do you exercise? | | | | | | | | | | | | | | |
| Regularly |  | | Irregularly | | |  | Occasionally | | |  | | Never | |  |
| What type of exercise do you undertake? | | | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | | |
| Skin type | | Dry | |  | Oily | | |  | Combination | |  | | Sensitive |  |
| Dehydrated | |  |  | | |  |  | |  | |  |  |
| Do you suffer or have you suffered from? | | Dermatitis | |  | Acne | | |  | Eczema | |  | | Psoriasis |  |
| Allergies | |  | Hay fever | | |  | Asthma | |  | | Skin cancer |  |
| Rate your stress level from 1 to 10 (10 being the highest). | | | | | | | | | | | | | | |
| At home | | | Choose an item. | | | | At work | | | | | Choose an item. | | |

# Treatment Information

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| womans-body |

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| **Figure diagnosis** | | | | | | | | | |
| Height | # | | Weight | # | Body type | Enter text | | BMI | # |
| Areas of soft fat | | Enter text. | | | Body shape | | Enter text. | | |
| Areas of cellulite | | Enter text. | | | Postural conditions | | Enter text. | | |

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| **Measurements** | | | | | | |
|  | | | | | R | L |
| Upper chest (under the arms) | # | Top of thigh 30 cm from knee | | | # | # |
| Maximum chest | # | 2 cm above knee | | | # | # |
| Below bust | # | Max calf | # | cm from ankle | # | # |
| Waist | # | Ankle above bone | | | # | # |
| Hips (hip bone) | # | Mid upper arm | | | # | # |
| Maximum buttocks (on hairline) | # | Mid lower arm | | | # | # |
|  |  | Wrist above bone | | | # | # |

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| **Tests** | | | | | | | | | | | | | | | | | |
| Nerve sensitivity test | | Yes |  | | No | |  | Heat sensitivity test | | | | Yes | |  | No |  | |
| **Muscle test** – *Select if / when 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 | | | |  |
| Buttocks | Excellent | | |  | | Good | | |  | Average |  | | Poor | | | |  |

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| **Treatment aim and details** – *To include products and equipment used* |
| Click or tap here to enter text. |

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| **Exercise advice** |
| Click or tap here to enter text. |

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| **Dietary advice** |
| Click or tap here to enter text. |

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| **Client feedback** |
| Click or tap here to enter text. |

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| **Aftercare / home care advice** |
| Click or tap here to enter text. |

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| **Therapist’s signature** |  |

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| **Client’s signature** |  | | |
| **BODY TREATMENTS AND FOLLOW-UP SHEET** | | **Date:** | Click or tap to enter a date. |

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| **Treatment aim and details** – *To include products and equipment used* |
| Click or tap here to enter text. |

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| **Client feedback** |
| Click or tap here to enter text. |

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| **Aftercare / home care advice** |
| Click or tap here to enter text. |

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| **Therapist’s signature** |  |

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| **Client’s signature** |  |

1. Cardiovascular conditions can include: thrombosis, phlebitis, hypertension, hypotension, heart conditions [↑](#footnote-ref-1)
2. Examples of nervous system dysfunctions: multiple sclerosis, Parkinson’s disease, motor neurone disease [↑](#footnote-ref-2)