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** |
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| 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)