CONFIDENTIAL SPORTS MASSAGE CONSULTATION & MEDICAL FORM

Name:	**Date:**	**Age:**	**Date of Birth :**
Email address:		**Phone no:**	
Emergency Contact:		**Tel No:**	
GP/Health Professional Name & Contact details: **Are you currently undergoing treatment from a GP/Health Professional for any condition? Yes No** **If YES give brief details:** **Initial here if you give your consent for your therapist to contact your doctor's surgery if they deem it necessary:**			
Are you on any medication/supplementation at present (including hormonal implants)? If YES please give name & dosage (if known):			
Have you had massage before?	**Type?**	**Pressure preference?**	
Primary reason for seeking treatment and desired outcome:			

To ensure you receive safe and effective treatment please answer the following questions. Any information given is treated in strict confidence and no advice will be sought without permission.

Do you have/suffer with (tick any applicable)?

- Contagious & Infectious Diseases, Fever, Skin Conditions, Under the influence of drugs or alcohol, Diarrhoea & Vomiting, Cancer (Unless in terminal stages and then with permission), Where there is tuberculosis in the joint

- Undiagnosed lumps or bumps
- Varicose veins
- Cuts and abrasions & Bruises & Haematomas
- Sunburn
- Undiagnosed pain
- Skin Disease, Eczema, Dermatitis, Psoriasis, Acne
- Abdomen in first few days of menstruation
- Inflammation – redness / swelling / pain / heat
- Digestive or urinary e.g. bloating, gallstones

- Hormonal implants
- Metal plates/ Pins
- Scar tissue – 2 years after major surgery / 6 mths after minor surgery
- Sprains/Strains/Hernia
- Recent fractures / Dislocations
- Gastric ulcers
- Heavy meal
- Conditions effecting the neck e.g. whiplash
- Localised swelling

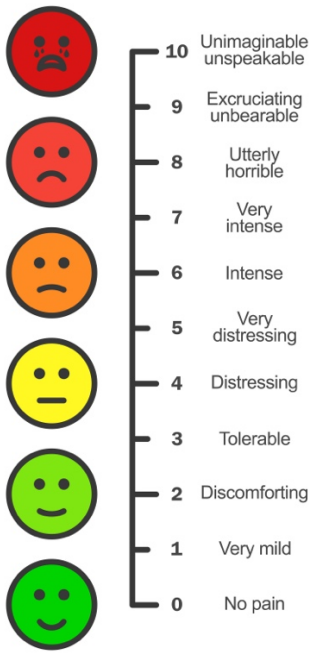
- Pregnancy - Are you pregnant or trying for a baby at present? (on the abdomen, with permission). How many weeks?
- Medical Oedema
- Arthritis / Acute Rheumatism
- Osteoporosis
- Epilepsy
- Diabetes
- Asthma
- Allergies e.g. nuts, pollen
- Haemophilia
- Recent operations (last 2 years)
- Trapped or pinched nerve
- Inflamed nerve
- Bells Palsy (temporary paralysis of facial muscles)
- Nervous / Psychotic conditions
- Fractures
- Prolapsed disc

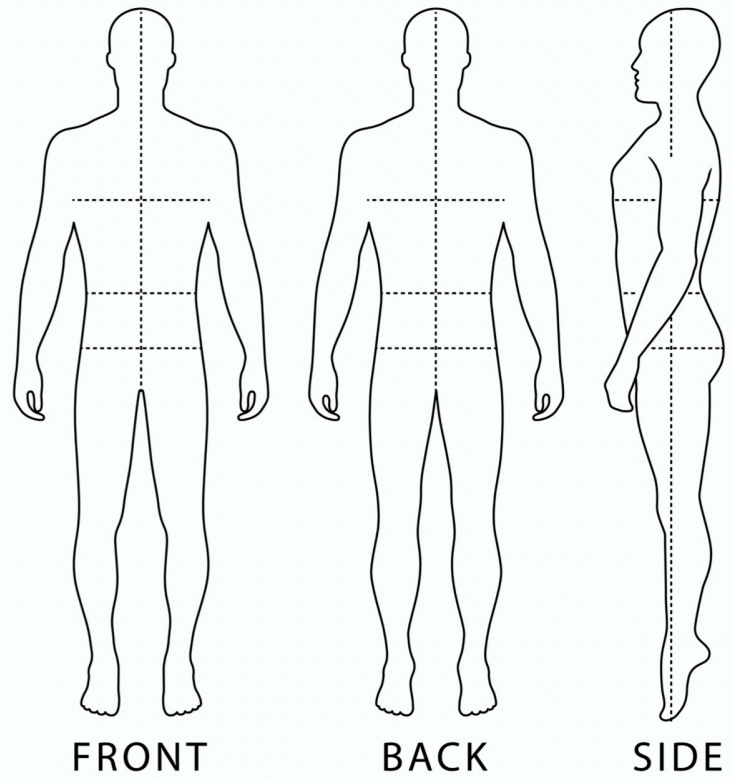
- Cardio vascular conditions eg Thrombosis, Embolism, DVT
- Stroke - Approximately 8-10 weeks laps should be allowed before massage is given after a stroke
- Phlebitis (vein inflammation)
- Hypertension / Hypotension
- Heart Conditions
- Chest infections e.g. bronchitis, pneumonia, pleurisy
- Cold hands /feet
- Dysfunction of the nervous system e.g. Parkinson's, MS, MN
- Accidents & injuries
- Where there is intestinal obstruction – Acute constipation with severe abdominal pain, and abdominal peristaltic action
- Never massage with any other medical condition you are not sure about or which is being treated by a GP or other Health care practitioner
- Central Nervous System: stress; anxiety; central sensitisation

Medical History: Hospital, ops, illness, accidents,	**Anything not mentioned above**
Contraindications (Red/Yellow flags)**:** YES NO	**Permission required by GP/ SPECIALIST** (attached to the consultation form): YES NO

Mandy Hurworth Registered Nutritionist & Clinical Massage Therapist

PHYSICAL EXAMINATION + TESTING (Postural holding patterns / compensation)





Indicate any SYMPTOMS:- Dizziness, Pins & needles, Nausea, Headaches, Numbness, Weaknesss, Clumsiness, Oedema, Cramps, Client personality/outlook (biopsychosocial), Other:

CLINICAL OBSERVATIONS & ASSESSMENT SUMMARY - Acute / Subacute/ Chronic

ROM/JOINT FLEX/EXT/ABD/ADD/ROTATION/ SUP/PRON/CIRC	**Pre-treatment Active/Passive/ Resisted**	**Post-treatment Active/Passive/ Resisted**
	Muscles Potentially Involved: based on: ROM agonist/antagonist; TP pain patterns; pathology	Structures Involved: bone, joint, muscle, tendon, ligament, nerves

TREATMENT SUMMARY & CLINICAL EVALUATION: (frequency/pland for next treatment)

Self-care Advice:

Aftercare Advice - Possible effects of treatment

- Headache, thirst, nausea
- Heightened emotions
- Fatigue
- Increased bladder & bowel movement

These are all normal whilst your body is eliminating unwanted toxins, so please do not worry. This should pass within 24 hours depending upon the amount of toxin build up within your body.

Informed Consent and GDPR

• Informed Consent:

• I have had a thorough consultation with my chosen practitioner

- I have been informed of the proposed treatment plan and agree to proceed with my therapist to address my specific needs.
- I understand that therapeutic massage is not a substitute for traditional medical treatment.
- I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional considerations based on my physical/ emotional/psychological condition.
- I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.

I_____confirm that the above information is accurate to the best of my knowledge and that I am happy to undergo treatment. I will keep my therapist up to date with any changes to my medical, mental & physical health.

Do you consent to be contacted by email or phone to organise further treatments ? Yes No

I would love to sign up to your newsletter and be contacted with all your practice updates: Yes No

Please note: I am obliged to make data available if contacted by Track & Trace.

I am obliged to give you a signed declaration included as part of this form to state:
a) I do not have and have not been in contact with anyone with Covid-19, in the last 14 days, to my knowledge
b) I have not had any symptoms: - dry cough, temp over 37.8°C, loss of smell and/or taste within the last 14 days
c) I have not been tested for Covid-19
d) Should I contract the virus I will inform you as soon as possible
e) Should either I, or a client, test positive for Covid-19 or contract the virus I am obliged to pass on contact details of anyone I have treated.

CLIENT/PARENT/GUARDIAN SIGNATURE:.....DATE:

THERAPIST'S SIGNATURE:.....DATE:

GDPR May 2018:
The data collected on this form will be used for the sole purpose of clinical massage and will not be disclosed to any external sources. For insurance purposes these records shall be kept for at least 7 years following the last occasion on which treatment was given.

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