



Client Consultation Form – *Stone Therapy Massage*

College Name:

Student Name:

College Number:

Student Number:

Client Name:

Date:

Address:

Sex: Male Female

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Profession:

Tel. No: Day..... Eve.....

GP Address:

PERSONAL DETAILS

Age group: Under 20 20–30 30–40 40–50 60+

Usual visit to Therapist:

Lifestyle: Active Sedentary

Last visit to the doctor:.....

No. Of children (if applicable):

Date of last period (if a applicable).....

CONTRAINDICATIONS: (tick where appropriate)

Any form of infection, disease or fever Under the influence of recreational drugs or alcohol Diarrhoea
Vomiting Pregnancy Cardio vascular conditions Haemophilia Any condition already being treated by
a GP or another complementary practitioner Medical oedema Osteoporosis Arthritis
Nervous/Psychotic condition Epilepsy Recent operations Diabetes Asthma Any dysfunction of
the nervous system Bells Palsy Trapped/Pinched nerve Inflamed nerve Skin cancer Cancer
Postural deformities Spastic conditions Kidney infections Whiplash Slipped disc Undiagnosed
pain When taking prescribed medication Acute rheumatism Skin diseases Undiagnosed lumps and
bumps Localised swelling Inflammation Varicose veins Pregnancy Cuts Bruises
Abrasions Scar tissue Sunburn Hormonal implants Abdomen(first few days of menstruation)
Haematoma Hernia Recent fractures Cervical Spondylitis Gastric ulcers After a heavy meal
Conditions affecting the neck

WRITTEN PERMISSION REQUIRED BY:

GP/Specialist Client Disclaimer

Either of which should be attached to the consultation form

PERSONAL INFORMATION

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 Chest Sinuses

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 yes, which ones

How much of each of these items does your diet contain?

Fresh fruit:..... Fresh vegetables:..... Protein: (source?)..... Dairy produce:.....

Sweet things:..... Added salt:..... Added sugar:.....

How many daily drinks of tea:..... Coffee:..... Fruit juice:..... Water:.....

Soft drinks:..... Others:.....

Do you suffer from food allergies? Yes No **Binging?** Yes No **Overeating?** Yes No

Do you smoke? No Yes How many per day?.....

Do you drink? No Yes How many units per 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)

Reason for treatment

Details of how the Therapist conducted the treatment.....
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Details of how the client felt during and after the treatment.....
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Details of home care advice given.....
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.....

Overall conclusion of the case study including reflective practice.....
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A client profile must be included in the case study.

Student's/Therapist's Signature

Client's Signature

Stone Therapy Massage – *Follow up Sheet*

Treatment Plan

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Treatment details

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Reactions during treatment

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Client feedback

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Overall conclusion of the case study including reflective practise

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Home care advice to include healthy eating and exercise

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