

## Personal Details

Full Name:		Date of 1 <sup>st</sup> Treatment	
Tel. No.		D.O.B.	
Email:		Referral:	
Emergency Contact:		Tel. No.	

### GP Information

GP Name/ Surgery		GP. Tel No.	
GP Address:		Initial here if you give your consent for your therapist to contact your doctor's surgery if they deem it necessary	

## Health History

Question:	Notes:
<input type="checkbox"/> Are/could you be pregnant? Number of wks?	
<input type="checkbox"/> Allergies	
<input type="checkbox"/> DVT/blood clot risk	
<input type="checkbox"/> Infection/colds/fever in the last week?	
<input type="checkbox"/> Skin conditions	

Any current medical conditions diagnosis'?

Are you currently taking any medication or supplements? If yes, how do they make you feel? Any noticeable side effects?

Are you currently under the care of any medical professionals/complementary health care practitioners?  
Details of treatment?

## Reason for seeking treatment

**OPQRS**

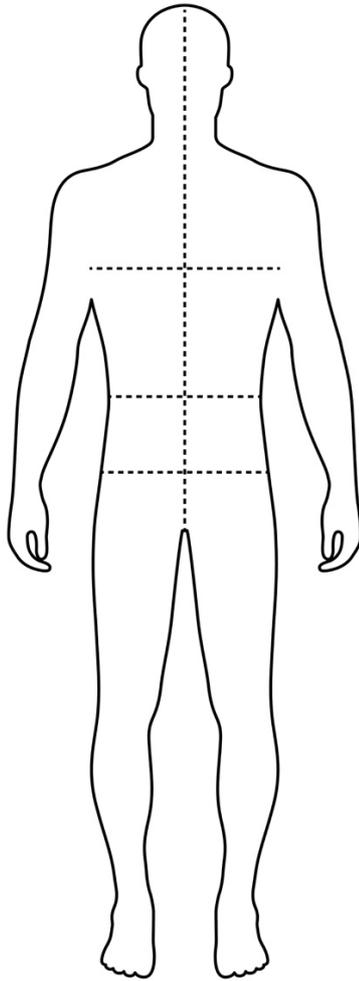
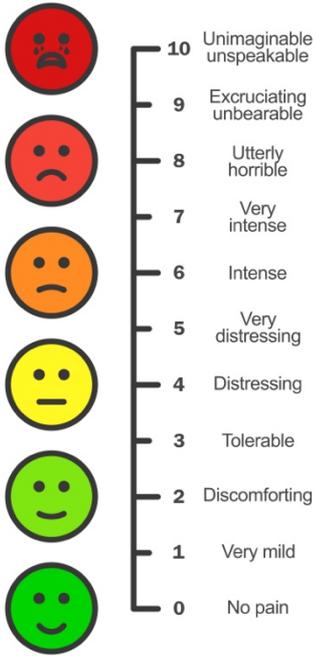
**SMART Outcome**

**Any Additional Information**

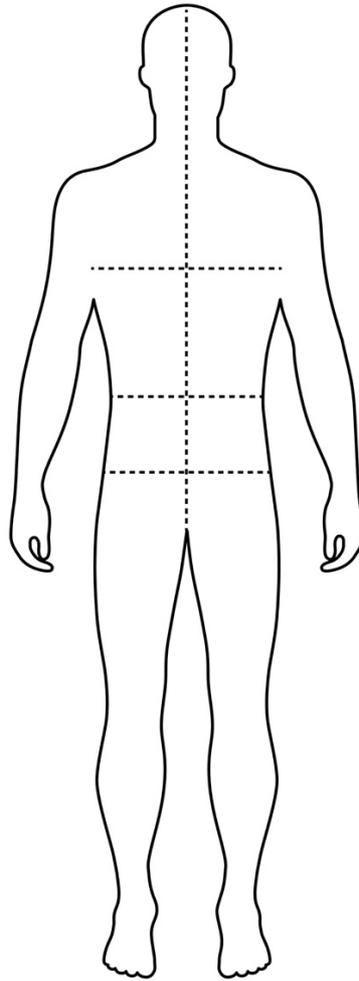
**Have you ever had a professional massage before? Have you experienced The Jing Method before?**

**If yes, what did you like/dislike? (Pressure? Favourite areas to be massaged? Any areas you dislike being touched?)**

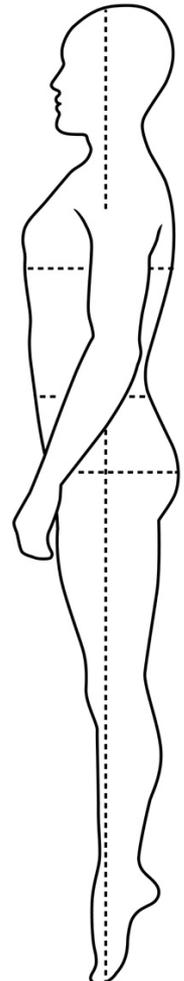
### Observation



FRONT



BACK



SIDE

### Observation Notes

Blank area for observation notes.









**Ankle – Talocrural Joint**

ACTION	MUSCLES INVOLVED	BEFORE TREATMENT						AFTER TREATMENT						
		RIGHT			LEFT			RIGHT			LEFT			
		P +/-	1-10	ROM	P +/-	1-10	ROM	P +/-	1-10	ROM	P +/-	1-10	ROM	
<b>Plantar Flex</b>	Gastroc, Soleus, Tib Post,													
<b>Dorsi Flex</b>	Tib Ant, Ext Dig Long, Ext Hall Long													

**Foot – Talotarsal, Midtarsal & Talometatarsal Joints**

ACTION	MUSCLES INVOLVED	BEFORE TREATMENT						AFTER TREATMENT						
		RIGHT			LEFT			RIGHT			LEFT			
		P +/-	1-10	ROM	P +/-	1-10	ROM	P +/-	1-10	ROM	P +/-	1-10	ROM	
<b>Evers</b>	Peroneals, Ext Dig Long													
<b>Invers</b>	Tib Ant, Tib Post, Flex Dig Long, Flex Hal Long, Ext Hal Long													

**Clinical Assessment Summary**

<ul style="list-style-type: none"> <li>• Acute / Subacute/ Chronic</li> <li>• Muscles Potentially Involved: based on: ROM agonist/antagonist; TP pain patterns; pathology</li> <li>• Possible pathology / Any suggested professional referral</li> <li>• Central Nervous System: stress; anxiety; central sensitisation</li> </ul>	<ul style="list-style-type: none"> <li>• Structures Involved: bone, joint, muscle, tendon, ligament, nerves</li> <li>• Postural holding patterns / compensation</li> <li>• Red / Yellow flags</li> <li>• Client personality / outlook (biopsychosocial)</li> </ul>
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## 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.

<b>Client Signature</b>		<b>Date:</b>	
<b>Therapist Signature</b>		<b>Date:</b>	

I would love to sign up to your newsletter and be contacted with all your practice updates

### 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.

## Treatment Notes

### Tx 1

**SMART Outcome:**

**Treatment Summary & Clinical Evaluation:**

**Plan for next treatment:**

**Self-care Advice/Online follow up appointment:**

**Client Feedback:**

**Date of Next Treatment:**

## Professional Reflective Notes