

Massage Therapy 3 Log Cover Sheet

Name: _____

Term: _____

Athlete's Initials: _____

Section: _____

Week	Giving		Receiving	Total	Total to Date
	Event*	Other			
	(13)		(4)	(17)	
Week 2					
Week 3					
Week 4					
Week 5					
Week 6					
Week 7					
Week 8					
Week 9					
Week 10					
Week 11					
Week 12					
Course Totals					

* No more than 3-6 hours of giving may be at events.

* With instructor's written permission, an additional 10 hours of log work may be given.

** A client who is active and/or has an identified musculoskeletal complaint. Must be approved by the instructor.

CLIENT QUESTIONNAIRE

In order to maximize the effectiveness and safety of our sessions together, we ask that you take the time to fill out this confidential questionnaire carefully.

Client Initials: _____ Client Number: _____ Date: _____ Referred by: _____

Address: _____

Phone (day): _____ (eve): _____ Date of Birth: _____

Occupation(s): _____

Age: _____ Height: _____ Weight: _____ Build: _____

What brings you here today?

Is there any area where you would like extra time spent? Is there any area where you have muscle pain/stiffness/tension (neck, low back, shoulder, other)?

What is your previous experience with professional massage?

Daily activities / sports / hobbies: _____

Habits: Exercise _____
Tobacco _____ Alcohol _____ Drugs (non-med.) _____
Posture assumed most of day _____
Caffeine _____ Sleep _____ Bowels _____

Medical History - Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area. Thank you.

_____ Skin condition (acne, rash, skin cancer, other):

_____ Allergies:

_____ Lymphatic condition (swollen glands, lymphoma, lymphedema, other):

_____ Recent injury or accident (whiplash, sprain, deep bruise, other):

_____ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis, other):

_____ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, other):

_____ Joint problems, pain, or stiffness (osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other):

_____ Bone conditions (osteoporosis, previous fracture, cancer, other):

_____ Headaches (migraines, PMS, tension, cluster, other):

_____ Emotional difficulties (depression, anxiety, psychotic episodes, other):

_____ Stress

_____ Previous surgery, please state type and date:

_____ Other medical considerations:

_____ List any medications you are currently taking:

_____ Are you pregnant?

Name of Health Care provider (not Insurance Co.): _____

Phone: _____

Do we have permission to contact him/her should the need arise? Yes _____ No _____

Client understands that the massage will be administered by a student enrolled in a massage program at the Connecticut Center for Massage Therapy. The student practitioner is not a licensed massage therapist.

The student practitioner is neither trained nor licensed to provide medical treatment to diagnose, prescribe drugs or medicines, perform spinal or other joint manipulations, nor any other service which a license to practice medicine, chiropractic, naturopathy, physical therapy, or podiatry is required by law.

Student practitioner, faculty, and school make no claims, representations, or guarantees about specific results. The goal of this session is primarily for the practice time of the student. If there are specific therapeutic needs perhaps a licensed therapist should be consulted.

Client has been provided with descriptions of the service and anticipated benefits. Client understands and agrees to the purpose, nature, and duration of the proposed service, and consents to receive this service.

Client understands that there can be remote risks associated with this work. Client acknowledges that the student practitioner, faculty, staff, and school will not be responsible for any injury arising because of some unreported condition and/or concern.

Client acknowledges being given the opportunity to ask questions before receiving any work, and to question or interrupt the work at any point after session begins.

Client acknowledges having read and understood this document.

Date

Client Initials only

Massage Therapy 3 Giving Logs

Date: _____ Client's initials: _____ Designated Athlete yes no
Time: (Check the time that applies) 15 min. 30 min. 45 min. 60 min. 75 min. 90 min.
Age: _____ Sex: Female Male Sport/Occupation _____

Strokes / Techniques Used:

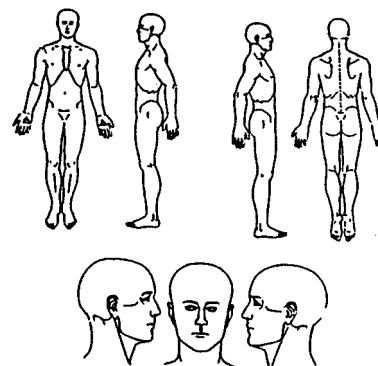
Compressions Broad Friction Specific friction Deep transverse friction Jostling
 Skin rolling Myofascial spreading Stripping Kneading Effleurage
 Ice Heat Cramp control protocol

Stretching (be specific) Static, muscles stretched: _____
 PNF - contract/relax, muscles stretched: _____
 PNF - reciprocal inhibition, muscles stretched: _____

Special Tests: (list) _____

S: SUBJECTIVE: The information your client tells you prior to the massage session. Problems/Concerns:

- Tightness, Pain, Tingling, Numbness, Restricted movement, Changes since last massage, Pertinent information from client questionnaire. What are client goals.



O: OBJECTIVE: Visual and palpatory observations regarding this client before and during the session.

- What qualities/characteristics do you observe about this client before session, visually (i.e. posture, movement patterns) and through your beginning palpation (i.e. texture of tissue, ropey bands, knots, hypertonic muscle, decreased ROM). What tests did you use (i.e. passive movement, resistive movement. To what areas/muscles.

A: ASSESSMENT: The changes that you observe in your client's body during and after the session.

- What changes did you notice in the areas documented under the subjective and objective sections. Note changes in tissue: tightness, ropey bands, tp, scar tissue, texture, ROM, pain, and to what degree these changed. What techniques facilitated change?

P: PLAN: Were your goals met. If not, what could you have done differently in order to meet the goals?

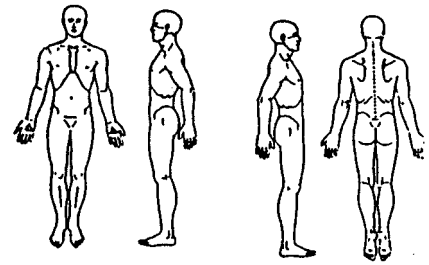
- What will you include next time, what will you not do again next time?

- Client Homework: What are you telling your client to do. (Example – ice, heat, movement, stretching (what kind, to what muscle))

SELF CARE: What were your body mechanics like throughout the massage.

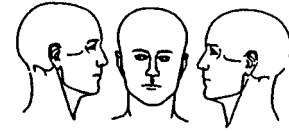
- Look at positioning of hands, wrist, feet, ASIS. Any discomfort/pain? How was table height? Any distractions?

Massage Therapy 3 Receiving Log



Date: _____
Therapist: _____
Client: _____
Time: _____

Problems/Concerns Expressed by Client: (tightness, pain, restricted ROM, active trigger points.)



Palpation Findings: (areas you were unaware of, muscles involved, texture of tissue as client perceives it; i.e. ropy bands, knots, broad tightness, trigger points.)

Techniques/Strokes Used: (strokes, heat, ice, stretching, ROM)

Results: (effect of strokes on areas of concern and palpation findings, what did and did not work and/or likes/dislikes)

Observations about Therapist: (pressure, professionalism, quality of strokes, communication/rapport, and environment)

