Voyage

International beauty est.2020

INDIAN HEAD MASSAGE

CASE STUDY BOOKLET

Learners Name:	
Date:	
Submission Date:	

INTRODUCTION:

Evidence of five (5) full sets of Indian Head Massage treatments to include:

1. Consultation
2. Contraindications
3. Analysis
4. Treatment details
5. Aftercare

CLIENT 1

DISCLAIMER

CLIENT INFORMATION

I _____ confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or consultant.

Client Signature:	Date:
Student / Therapist Signature:	Date:

CLIENT CONSENT FORM AND CONSULTATION CARD – INDIAN HEAD MASSAGE

Date of Consultation: _____

Therapist Name: _____

CLIENT PERSONAL DETAILS:

Name: _____

Date of Birth: _____

Address: _____

Occupation: _____

Lifestyle: Active / Sedentary: _____

Telephone Number:

(C) _____ (H) _____ (W) _____

MEDICAL HISTORY:

Personal Doctor: _____ Tel. No: _____

Date of last visit to Doctor: _____

Date of last menstrual cycle: _____

Current Medication: _____

CONTRA-INDICATIONS

Recent Surgery	Y / N	
Pregnancy		
Diabetes		
Cardiac Problems		
Diabetes		
Epilepsy		
Heart Disease / Pacemaker		
Skin Diseases		
Thyroid Problems		
Hormonal Imbalances		
Metal Pins/Plates		
Eating Disorder		
Liver Ailments		
Kidney Ailments		
Cancer		
Spastic Colon		
Claustrophobia		

GENERAL HEALTH:

General Health	Good	Poor	
Do you suffer from stress and tension?	Yes	No	
Do you smoke?	Yes	No	How many a day?
Do you drink alcohol?	Yes	No	How often?
Do you drink tea/coffee?	Yes	No	
Do you drink plain still water?	Yes	No	
Do you take vitamins/minerals?	Yes	No	
Medication...	Yes	No	

TREATMENT:
Treatment Plan:

Details of how the client felt during the treatment:

Details of how the client felt after the treatment:

Home Care Advice:

Reflective Practice:

Overall Conclusion:

CONSENT:
I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-care instructions. Prior to receiving any treatment, I have been candid in revealing any condition that may have bearing on this procedure.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CLIENT 2

DISCLAIMER

CLIENT INFORMATION

I _____ confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or consultant.

Client Signature:	Date:
Student / Therapist Signature:	Date:

CLIENT CONSENT FORM AND CONSULTATION CARD – INDIAN HEAD MASSAGE

Date of Consultation: _____

Therapist Name: _____

CLIENT PERSONAL DETAILS:

Name: _____

Date of Birth: _____

Address: _____

Occupation: _____

Lifestyle: Active / Sedentary: _____

Telephone Number:

(C) _____ (H) _____ (W) _____

MEDICAL HISTORY:

Personal Doctor: _____ Tel. No: _____

Date of last visit to Doctor: _____

Date of last menstrual cycle: _____

Current Medication: _____

CONTRA-INDICATIONS

Recent Surgery	Y / N	
Pregnancy		
Diabetes		
Cardiac Problems		
Diabetes		
Epilepsy		
Heart Disease / Pacemaker		
Skin Diseases		
Thyroid Problems		
Hormonal Imbalances		
Metal Pins/Plates		
Eating Disorder		
Liver Ailments		
Kidney Ailments		
Cancer		
Spastic Colon		
Claustrophobia		

GENERAL HEALTH:

General Health	Good	Poor	
Do you suffer from stress and tension?	Yes	No	
Do you smoke?	Yes	No	How many a day?
Do you drink alcohol?	Yes	No	How often?
Do you drink tea/coffee?	Yes	No	
Do you drink plain still water?	Yes	No	
Do you take vitamins/minerals?	Yes	No	
Medication...	Yes	No	

TREATMENT:

Treatment Plan:

Details of how the client felt during the treatment:

Details of how the client felt after the treatment:

Home Care Advice:

Reflective Practice:

Overall Conclusion:

CONSENT:

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-care instructions. Prior to receiving any treatment, I have been candid in revealing any condition that may have bearing on this procedure.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CLIENT 3

DISCLAIMER

CLIENT INFORMATION

I _____ confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or consultant.

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Student / Therapist Signature:	Date:

CLIENT CONSENT FORM AND CONSULTATION CARD – INDIAN HEAD MASSAGE

Date of Consultation: _____

Therapist Name: _____

CLIENT PERSONAL DETAILS:

Name: _____

Date of Birth: _____

Address: _____

Occupation: _____

Lifestyle: Active / Sedentary: _____

Telephone Number:

(C) _____ (H) _____ (W) _____

MEDICAL HISTORY:

Personal Doctor: _____ Tel. No: _____

Date of last visit to Doctor: _____

Date of last menstrual cycle: _____

Current Medication: _____

CONTRA-INDICATIONS

Recent Surgery	Y / N	
Pregnancy		
Diabetes		
Cardiac Problems		
Diabetes		
Epilepsy		
Heart Disease / Pacemaker		
Skin Diseases		
Thyroid Problems		
Hormonal Imbalances		
Metal Pins/Plates		
Eating Disorder		
Liver Ailments		
Kidney Ailments		
Cancer		
Spastic Colon		
Claustrophobia		

GENERAL HEALTH:

General Health	Good	Poor	
Do you suffer from stress and tension?	Yes	No	
Do you smoke?	Yes	No	How many a day?
Do you drink alcohol?	Yes	No	How often?
Do you drink tea/coffee?	Yes	No	
Do you drink plain still water?	Yes	No	
Do you take vitamins/minerals?	Yes	No	
Medication...	Yes	No	

TREATMENT:
Treatment Plan:

Details of how the client felt during the treatment:

Details of how the client felt after the treatment:

Home Care Advice:

Reflective Practice:

Overall Conclusion:

CONSENT:
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Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CLIENT 4

DISCLAIMER

CLIENT INFORMATION

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Student / Therapist Signature:	Date:

CLIENT CONSENT FORM AND CONSULTATION CARD – INDIAN HEAD MASSAGE

Date of Consultation: _____

Therapist Name: _____

CLIENT PERSONAL DETAILS:

Name: _____

Date of Birth: _____

Address: _____

Occupation: _____

Lifestyle: Active / Sedentary: _____

Telephone Number:

(C) _____ (H) _____ (W) _____

MEDICAL HISTORY:

Personal Doctor: _____ Tel. No: _____

Date of last visit to Doctor: _____

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CONTRA-INDICATIONS

Recent Surgery	Y / N	
Pregnancy		
Diabetes		
Cardiac Problems		
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Hormonal Imbalances		
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Liver Ailments		
Kidney Ailments		
Cancer		
Spastic Colon		
Claustrophobia		

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General Health	Good	Poor	
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Do you drink alcohol?	Yes	No	How often?
Do you drink tea/coffee?	Yes	No	
Do you drink plain still water?	Yes	No	
Do you take vitamins/minerals?	Yes	No	
Medication...	Yes	No	

TREATMENT:

Treatment Plan:

Details of how the client felt during the treatment:

Details of how the client felt after the treatment:

Home Care Advice:

Reflective Practice:

Overall Conclusion:

CONSENT:

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Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CLIENT 5

DISCLAIMER

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Student / Therapist Signature:	Date:

CLIENT CONSENT FORM AND CONSULTATION CARD – INDIAN HEAD MASSAGE

Date of Consultation: _____

Therapist Name: _____

CLIENT PERSONAL DETAILS:

Name: _____

Date of Birth: _____

Address: _____

Occupation: _____

Lifestyle: Active / Sedentary: _____

Telephone Number:

(C) _____ (H) _____ (W) _____

MEDICAL HISTORY:

Personal Doctor: _____ Tel. No: _____

Date of last visit to Doctor: _____

Date of last menstrual cycle: _____

Current Medication: _____

CONTRA-INDICATIONS

Recent Surgery	Y / N	
Pregnancy		
Diabetes		
Cardiac Problems		
Diabetes		
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Hormonal Imbalances		
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Do you drink plain still water?	Yes	No	
Do you take vitamins/minerals?	Yes	No	
Medication...	Yes	No	

TREATMENT:
Treatment Plan:

Details of how the client felt during the treatment:

Details of how the client felt after the treatment:

Home Care Advice:

Reflective Practice:

Overall Conclusion:

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