2nd Wind Sports Therapy
"Restore Natural Movement"

#2ndwindsportstherapy @2ndwindsportstherapy

Client Consultation Form

PERSONAL DETAILS
Name & Surname:_____
Date of Birth: _____ **Age:**_____
Lifestyle: Active ☐ **Sedentary** ☐
No. Of children (if applicable): _____ **Date of last period (if applicable):** _____

MEDICAL CONDITIONS (*select if/where appropriate*):

Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) ☐
Haemophilia ☐
Any condition already being treated by a GP or another health professional, e.g. Physiotherapist, Osteopath, Chiropractor, Coach ☐
Medical oedema ☐ Osteoporosis ☐
Arthritis ☐ Nervous/Psychotic conditions ☐
Epilepsy ☐ Recent operations ☐
Diabetes ☐ Asthma ☐
Any dysfunction of the nervous system (e.g. Muscular sclerosis, Parkinson's disease, Motor neurone disease) ☐

Bells Palsy ☐
Trapped/Pinched nerve (e.g. sciatica)
Inflamed nerve ☐
Cancer ☐ Postural deformities ☐
Spastic conditions ☐ Kidney infections ☐
Whiplash ☐ Slipped disc ☐
Undiagnosed pain ☐
Taking prescribed medication ☐
Acute rheumatism ☐

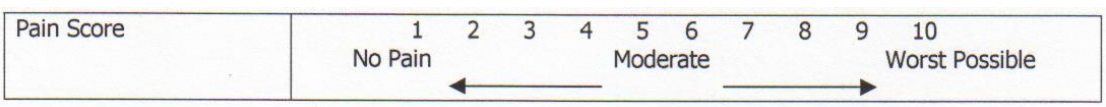
CONTRAINDICATIONS THAT MAY RESTRICT TREATMENT (*select if/where appropriate*):
Fever ☐ Contagious or infectious diseases ☐
Under the influence of recreational drugs or alcohol ☐
Diarrhoea and vomiting ☐ Skin diseases ☐
Undiagnosed lumps and bumps ☐ Localised swelling ☐
Inflammation ☐ Varicose veins ☐
Cuts ☐ Bruises / Abrasions ☐
Scar tissues (2 years for major operation and 6 months for a small scar) ☐

Hormonal implants ☐
Haematoma ☐
Hernia ☐
Recent fractures (minimum 3 months) ☐
Cervical spondylitis ☐
Gastric ulcers ☐

WRITTEN PERMISSION REQUIRED BY GP/SPECIALIST *(which should be attached to the consultation form)*:
Yes ☐ No ☐

PERSONAL INFORMATION *(select if/where appropriate)*:
Muscular/Skeletal problems: Back☐ Aches/Pain☐ Stiff joints☐ Headaches☐
Circulation: Heart☐ Blood pressure☐ Fluid retention☐ Tired legs☐ Varicose veins☐
Nervous system: Migraine☐ Tension☐ Stress☐ Depression☐ **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:
Do you suffer from food allergies? Yes☐ No☐ **Do you exercise?** None☐ Occasional☐ Irregular☐ Regular☐ Type:
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) At work ☐ At home ☐

Current Medical Condition/Treatment
Pain Nature Onset ☐ Duration ☐ Daily Pain Pattern
Aggravates Sitting ☐ Standing ☐ Walking ☐ Running ☐
Eases



Medical In Confidence

What treatment was undertaken?
How long did the injury take to heal?
Did you have any investigations? Yes ☐ No ☐ If yes, which ones:

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INFORMED CONSENT TO THERAPETUTIC MASSAGE TREATMENT AND MYOFASCIAL RELEASE

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Allied Health Professions Council, South Africa.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I HEREBY DECLARE THAT I UNDERSTAND THE FOLLOWING:

The Lyno Method is a complimentary health technique with the aim to analyze and restore holistic movement in the body. Restrictions in movement due to periods of immobilization, overuse or old injuries and surgery, may lead to compensation patterns and unnecessary imbalances and wear and tear in the body.
The body is designed to heal itself, but in order to do so it needs access to amongst other factors, also efficient and balanced movement.
Lyno is a team effort and the outcome relies on the cooperation and feedback of the patient. Our goal is to empower our clients to be able to eventually manage their own bodies in order to stay injury-free and healthy.

A Lyno session consists of the following 3 steps:

Step 1: A full holistic analysis of the client's habitual movement patterns and function
Step 2: The introduction and facilitation of neutral and balanced movement
Step 3: Functional exercises to maintain movement and function in the client's daily routine

The Lyno Technique

The Lyno technique is a dynamic modality where the client and practitioner work together to facilitate movement in stagnant areas. The practitioner will attempt to move the skin in one direction while the client actively moves in the opposite direction. The combination of movement 'melts' the densified hyaluronic acid between the layers of muscle and connective tissue and restores natural movement. Hyaluronic acid is the substance, which is responsible for the sliding of all surfaces in the body upon each other.
The client determines the intensity of the technique, which is experienced as a burning sensation on the skin.
In some cases the technique may leave a red line on the surface on the skin, consisting of tiny red dots. This reaction is due to a histamine reaction to released toxins and only appears in areas where movement was hugely restricted. The lines disappear within a few hours to a few days.
Please note that due to the release of toxins, you may experience detox symptoms after sessions, i.e. headaches, cold shivers, flu symptoms etc. Please drink lots of water to prevent these symptoms.
Since we will be removing several 'layers' of compensation patterns, clients may initially feel even more off-balance and symptoms of 'old injuries' may surface again. As the quality of movement improves, these sensations will change and you will feel looser and more functional.
If pathology is suspected, you will be referred to a medical professional.

NAME & SURNAME _____ **SIGNATURE** _____ **DATE** _____

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