



Lauterstein-Conway
Massage School & Clinic

Outside Massage Form #5: Orthopedic: Piriformis & Sacroiliac OR Low Back Pain

Client _____ Due Date _____ Class 85a _____

Student _____ Group _____ Date _____

Client Feedback:

Information you supply about your own particular experience of this massage will be important for the student's education. In the space below please be specific about how the massage felt to you and what changes you notice in your body, mind, or spirit as a result. Any suggestions you have will be appreciated. Thank you.

Student Notes:

In this space the student records information about the session when finished. Impressions, objective and subjective information, remarks about how you feel the massage went, etc. Include any questions that may have come up for you. What did you learn?

CLIENT INTAKE FORM

Date: _____

Full Name: _____ Preferred Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: ____/____/____ Gender Identity: _____ Preferred Pronouns: _____

Height: ____' ____" Approx. Weight: _____ lbs Occupation: _____

Email: _____

Emergency Contact Name:	Relationship:	Phone:

What types of healthcare are you receiving? (*Physician, Chiropractor, Acupuncture, Homeopath, etc.*)

Do you currently have, or recently had, any of the following conditions?:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Numbness or Tingling	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Heart Conditions
<input type="checkbox"/> Cancer (History)	<input type="checkbox"/> Skin Conditions	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Allergies	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Spinal Conditions

Please elaborate if you selected any of the above conditions:

Please note any recent injuries, surgeries, major accidents, or serious illness/conditions:

Please list any medications or supplements you are currently taking for any of the above conditions:

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes: Due Date _____

Previous massage/bodywork experience: ☐ Never ☐ Occasionally ☐ Often: Type(s) _____

I understand that: Massage therapy (Which include styles of: Swedish, Sports, Deep Tissue or Deep Massage) involves neither diagnosis nor treatment of any condition and is not a substitute for medical care. Draping will be used at all times. This is a full-body massage unless otherwise requested. Neither breasts nor genitalia will be massaged. I may itemize here any areas on my body that I wish to be avoided, and these will be totally avoided (itemize here if relevant):

If I am uncomfortable for any reason I may request to end the session and it will end promptly. If client is under the age of 17, written consent from client's guardian or parent is required. I affirm that I am able to receive Massage Therapy and that any of the information I have provided above does not prohibit me from doing so. I am aware that if I have a medical diagnosis that prohibits me from receiving Massage I must provide physicians written consent prior to services.

Client Signature: _____ Therapist Signature: _____

The provided information is confidential and may be important to your therapy. Clients are asked to keep the clinic informed on changes. This is a student internship and table-side instruction may take place. Therefore, you may notice light talking between instructors and students during your treatment.

Treatment Record

Client Name _____

Date _____

Student Therapist _____

S: Subjective or what the client reports about their status
(client goals, functional limitations, and diagnosis/clearance from a physician)

O: Objective or findings made by the therapist
(client posture, client movement, palpation of client during interview, details of focus area treatment)

Prone:

Supine:

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A: Assessment or how the client rates the pain or discomfort of a focus area
(0-10, 0 = no pain, 5 = moderate pain, 10 = worst possible pain, recorded before and after treatment)

Before treatment:

After treatment:

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

P: Plan or a strategy for further care
(client education, self care such as movement or stretches, future massage session ideas, referrals)

Personal reflection or meaningful insights made by the therapist about the therapist

Technique Check List

BMTs - Prone

- ☐ Spinal Rotation & Release with Erector Compressions
- ☐ Shoulder Mobilization with Trapezius Compressions
- ☐ Scapular Mobilization with Trapezius & Deltoid Compressions
- ☐ Deltoid & Triceps Brachii Coarse Vibration
- ☐ Gluteal & Hamstring Compression with Knee & Hip Mob.
- ☐ Ankle Mobilization with Gastrocnemius Compressions
- ☐ One Handed Gastrocnemius & Soleus Jostling
- ☐ Ankle & Knee Mobilization with Plantar Compressions
- ☐ Prone Full Body Rocking Compressions

BMTs - Supine

- ☐ Supine Hip Rotation with Leg Compressions
- ☐ Pulsing Hip Traction from the Ankle
- ☐ Hip Medial Rotation & Release from the Ankle
- ☐ Unilateral Ribcage Compression and Mobilization
- ☐ Bilateral Upper Ribcage Compressions
- ☐ Shoulder Mobilization with Pectoral Compressions
- ☐ Supine Deep Lateral Friction & Release on the Rhomboids
- ☐ Wrist, Elbow & Shoulder Mobilization
- ☐ Head & Neck Rotation with Post. Cervical Comp. & Release
- ☐ Alternating Scapular Depression with Trapezius Comp.

Deep Tissue - Prone

- ☐ Infraspinatus and teres major: deep effleurage
- ☐ Triceps brachii: deep effleurage
- ☐ Upper traps, supraspinatus, levator scapula: deep effleurage
- ☐ Rhomboids: deep effleurage
- ☐ Erector spinae: deep effleurage
- ☐ Quadratus lumborum: deep effleurage
- ☐ Lats, erectors, and gluteals: broad cross fiber
- ☐ Gluteus maximus: deep effleurage
- ☐ Hamstrings: deep effleurage
- ☐ Hamstrings: deep transverse friction and melting
- ☐ Gastrocnemius and soleus: deep effleurage
- ☐ Gastrocnemius and soleus: stripping

Deep Tissue - Supine

- ☐ Tensor fasciae latae: BMT fiber spreading
- ☐ Sartorius and vastus medialis: deep effleurage
- ☐ Rectus femoris, vastus lateralis, and I.T. tract: deep effleurage
- ☐ Distal quadriceps: petrissage / wringing / fiber spreading
- ☐ Tibialis anterior & ankle / toe extensors: deep stripping
- ☐ Pectoralis major: compressive effleurage
- ☐ Pectoralis major: superficial and deep friction
- ☐ Anterior deltoid, biceps, brachialis: BMT fiber spreading
- ☐ Forearm flexors and extensors: superficial and deep friction
- ☐ Forearm flexors and extensors: Stripping with traction
- ☐ Thenar and hypothenar eminences: cross fiber friction

Passive Stretches - Prone

- ☐ Quadriceps femoris

Passive Stretches - Supine

- ☐ Low back
- ☐ Gluteals
- ☐ Adductors
- ☐ Tibialis anterior
- ☐ Gastrocnemius and soleus
- ☐ Pectoralis major
- ☐ Latissimus dorsi
- ☐ Rhomboids
- ☐ Neck lateral flexion
- ☐ Neck rotation

Orthopedic - Piriformis & Sacroiliac

- ☐ S.I. ligament: deep transverse friction
- ☐ Piriformis: deep longitudinal stripping
- ☐ Piriformis: pin and stretch
- ☐ Piriformis: PIR deep longitudinal stripping
- ☐ Piriformis: passive stretching after PIR

Orthopedic - Low Back Pain

- ☐ Lumbar & lamina groove: deep stripping
- ☐ QL: deep longitudinal stripping
- ☐ QL: pin and stretch with active engagement
- ☐ QL: active assisted stretch after PIR
- ☐ Iliopsoas: active-assisted stretch after PIR

Orthopedic - Rotator Cuff & Carpal Tunnel

- ☐ Transverse carpal ligament: myofascial release
- ☐ Supraspinatus tendon: deep transverse friction
- ☐ GH rotators: stripping w / active engagement
- ☐ GH rotators: passive stretch
- ☐ Subscapularis: deep friction and melting

Orthopedic: Thoracic Outlet

- ☐ Vertebrobasilar sufficiency test (VBI test)
- ☐ Pectoralis minor: pin and stretch
- ☐ Scalenes: stripping after PIR
- ☐ Scalenes: stripping with active lengthening
- ☐ Brachial plexus: nerve mobilization

Orthopedic: Neck Pain

- ☐ Posterolateral neck: deep stripping
- ☐ Cervical lamina groove: deep stripping
- ☐ Cervical extensors: PIR deep stripping
- ☐ Cervical lateral flexors: PIR deep stripping
- ☐ Passive Stretches: lateral flexion and rotation



**Lauterstein-Conway
Massage School & Clinic**

Outside Massage Form #6: Orthopedic: Rotator Cuff & Carpal Tunnel OR Thoracic Outlet

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Student _____ Group _____ Date _____

Client Feedback:

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Full Name: _____ Preferred Phone: _____

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DOB: ____/____/____ Gender Identity: _____ Preferred Pronouns: _____

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| <input type="checkbox"/> Allergies | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Spinal Conditions |

Please elaborate if you selected any of the above conditions:

Please note any recent injuries, surgeries, major accidents, or serious illness/conditions:

Please list any medications or supplements you are currently taking for any of the above conditions:

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BMTs - Supine

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- ☐ Passive Stretches: lateral flexion and rotation