VERSION 1.0 | November 2026 | Therapist study use

Session documentation

Therapist record | wellness service only unless independently qualified for specialist clinical practice

Client ID / name: _____ Date: _____

Therapist: _____ Venue: [ ] Clinic [ ] Home

Session number: _____ Start / end: _____ Duration: _____ min

Health update and pre-session check

[ ] No new concerning symptoms or changes since last review

[ ] Screening updated; contraindications checked

[ ] New or worsening symptoms: treatment deferred and/or referred

[ ] Consent confirmed for treatment regions and positions

New symptoms, medication changes, relevant clinical advice:

_____

_____

_____

Goals and consent

Client-stated goal: _____

Regions consented to: _____

Treatment record

Region / position	Technique or movement family	Time / client response
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Client response and aftercare

_____

_____

_____

Any adverse reaction? [ ] No [ ] Yes - details and action: _____

Advice given, referral, planned review and objective/subjective outcome:

_____

_____

_____

Signed: _____ Date/time: _____