# Reflexology Consultation

| | | |
|---|---|---|
| | Name: | DOB & Age: |
| | Address: | Phone number – Home:<br><br>Phone number – Mobile: |
| **Occupation:** | | **Height / Weight / Build:** |
| **GP's Name & Address:** | | |
| **Reason for Visit:** | | |

**Medical Background**

| | |
|---|---|
| Muscular system: (injuries, aches or pains in muscles& joints) | ☐ Yes ☐ No |
| Skeletal system: (injuries, fractures, arthritis) | ☐ Yes ☐ No |
| Circulatory system: (heart, angina, thrombosis, varicose veins, fluid retention, family history) | ☐ Yes ☐ No |
| Blood pressure: (hypertension, hypotension, medication, stable, unstable) | ☐ Yes ☐ No |
| Lymphatic system: (swelling in lymph glands, tonsils, adenoids, frequent infection) | ☐ Yes ☐ No |
| Urinary system: (kidney or bladder infections, cystitis, pain or pressure on passing urine, prostrate problems) | ☐ Yes ☐ No |
| Digestive system: (constipation, bloating, heartburn, cramps) | ☐ Yes ☐ No |
| Respiratory system: (bronchitis, asthma, sinusitis, ear infections, cough) | ☐ Yes ☐ No |
| Nervous system: (headaches, migraine, tension, stress, anxiety depression) | ☐ Yes ☐ No |
| Reproductive system: (menstruation, regularity, heavy or scant flow, length of cycle, associated pain, contraceptive pill) | ☐ Yes ☐ No |
| Pregnancy: (number, multiple births, history of miscarriage) | ☐ Yes ☐ No |
| Menopausal: (hot flushes, mood swings, HRT) | ☐ Yes ☐ No |
| Skin: (dry, oily, combination, sensitive) | ☐ Yes ☐ No |
| Skin conditions: (dermatitis, acne, eczema, psoriasis, skin allergies) | ☐ Yes ☐ No |

| | |
|---|---|
| Cancer: (diagnosis, date, treatment, medication, prognosis, remission, family history) | ☐ Yes ☐ No |
| Allergic reactions: (triggers e.g. medication, food, additives) | ☐ Yes ☐ No |
| Diabetes: (stable, unstable, diet or medically controlled, family history) | ☐ Yes ☐ No |
| Operations: (dates, locations, scarring) | ☐ Yes ☐ No |
| Sleep: (pattern, duration, ease of getting to sleep, wake feeling refreshed, disturbed) | |
| Exercise: (type & frequency) | |
| Medications: prescribed, supplements, over the counter) | |
| Diet: (normal, reduction, gluten free, diabetic) | |
| Daily fluid intake: ☐ Water ☐ Tea ☐ Coffee ☐ Fruit Juice ☐ Other | |
| Smoking: ☐ No ☐ Yes – How many per day? | |
| How would you rate your stress levels on a scale from 1 – 10 (10 being the highest)? | |

## Additional Information

## Declaration

I hereby declare that I have answered the consultation fully and I have not withheld any information that may affect the outcome of the treatment. Treatment has been fully explained and I have been made aware of any possible reactions which could occur.

I know of no reason why I cannot undertake reflexology treatment. It is my responsibility to notify the therapist of any medical changes that may affect any treatment either now or in the future.

☐ **I give permission for you to hold my records in order to deliver your services.**

Client Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____