CONSULTATION FORM

Pregnancy Reflexology

Date of consultation: ……. **Pregnancy (week):** ……..……

Personal Details:

Title: …… Name ……..……

Address: ……..……...

..……...…… Postcode:…….

No. of Children:…….…...…..……..… Date of Birth: …..……

Profession: ……..……..Phone No: …….…….……

E-mail: ……..…….

Primary care provider name and address:..……..……..…….

…….……..……..……..……

Last visit to Primary care provider:..……..……..……..…….

Next to kin (available support): …… Phone No:……...

Number of pregnancies: …… Was recent pregnancy planned? No □ Yes □

For history of previous pregnancies complete section 2.

1. Section: Do you suffer from the following?

Sinuses □	Morning sick. □	Depression □	Asthma □	Diabetes □	Groin pain □
Anaemia □	Panic attacks □	Diarrhoea □	Sciatica □	Insomnia □	Varicose vein □
Oedema □	Mood swings □	Heartburn □	Epilepsy □	Ribs pain □	Tender breasts □
Cystitis □	Constipation □	Headaches □	Migraine □	Itchy skin □	Haemorrhoids □
Fatigue □	Stretch marks □	Palpitation □	Backache □	Diarrhoea □	

Frequent Micturition □	Symphysis pubis laxity □	Carpal tunnel syndrome □
Low blood pressure □	Pelvic girdle instability □	Braxton Hicks contractions □
High blood pressure □	Abdominal pain □	Sensory loss (numbness) □
Urination problem □	Vaginal bleeding □	Leg cramping or pain □

Clotting issue (suspected deep vein thrombosis) □ Protein, sugar or blood in urine (if known) □

Skin diseases (Eczema, Acne, Dermatitis, Psoriasis, other) □……..

Other: …….

Address: 5 Earlspark Crescent, Bieldside, Aberdeen, AB15 9AY
Website: www.ainetherapies.co.uk E-mail: info@ainetherapies.co.uk
Mobile: 07798 557454

Aids or STD: ……...…….

Current medical treatment (if any):..……

Current medication (or homeopathic, vitamins):……..……

……

How would you describe your diet? (Portions/cups a day)

Veg/Fruit…… Dairy Produce…… Sweet Things….. Protein cont. food…….…….

Tea……. Coffee……. Water……. Soft Drinks…….. Other…….

Vitamines/Minerals Supplements …….

Food or other allergies? No □ Yes □ ..……..……..……..

Do you smoke? No □ Yes □ Do you drink alcohol? No □ Yes □

General state of health:

Stress levels: *home:* High □ Medium □ Low □ *work*: High □ Medium □ Low □

Sleep pattern: Good □ Average □ Poor □

Ability to relax: Good □ Average □ Poor □

Working at computer: No □ Yes □ (hours daily/weekly) ……..…

Recent exercises: ……..……..……

Have you had a Complementary Treatment before? No □ Yes □ (recently?)…..…….

Client declaration:

You do not need to fill up and sign next page if this is your first pregnancy.

I declare that the information I have given is correct and that as far I am aware I can undertake treatment without any adverse effects. I do not suffer any contagious diseases (Diarrhoea, vomiting, etc.), which could spread to other clients coming to the clinic and I am not under the influence of recreational drugs or alcohol. I have been fully informed about the treatment and any contraindications and I am willing to proceed. I understand that any complementary therapy treatment does not substitute medical treatment. I agree that my data can be securely stored by A'INE Complementary Therapies, who will not share data with third parties without prior consent.

Client Signature: …….. Date: ……..

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2. Details of previous pregnancies:

Previous pregnancies?	1	2	3	4
Was the pregnancy normal?				
Did you suffer any ailments?				
Was the delivery normal?				
Pre-term, on time, overdue?				
Were you induced?				
Did you have an epidural?				
Assisted delivery (how)?				
Did you have stitches?				
Did you breast feed?				
Any postnatal problems?				

Other notes:

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