CONSULTATION FORM

Reflexology

Client Note:

The following information is required for your safety and to benefit your health. There are certain conditions, which may require special care and in some instances it may be necessary for you to consult your GP before any treatment can be given. Please fill in or tick the box as appropriate. The information given will be treated in the strictest of confidence.

Date of consultation: ……..

Personal Details:

Title: …… Name ……..……

Address: ……..……...

..……...…… Postcode:

…….

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

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

E-mail: ……..…….

GP name and address: ……..…….

……..…….…….

Contraindications requiring medical permission: In circumstances where medical permission cannot be obtained client must give informed consent in writing prior to treatment.

Cardio vascular conditions □ (thrombosis, phlebitis, high or low blood pressure, heart conditions)

Nervous system dysfunction □ (Muscular sclerosis, Parkinson's disease, Motor neurone disease)

Osteoporosis □ Arthritis □ Acute rheumatism □ Pregnancy □ Spastic condition □

Medical oedema □ Diabetes □ Kidney infections □ Epilepsy □ Inflamed nerve □

Nervous/Psychotic conditions □ Trapped/Pinched nerve (e.g. sciatica) □ Asthma □ Cancer □

Recent operations □ ……..

Other condition being treated by GP or another complementary therapist:……...

Prescribed medication:……...

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Mobile: 07762324001

Localised Contraindications:

Localised swelling □ Inflammation □ Sunburn □ Varicose veins □ Haematoma □

Cuts/Bruises/ Abrasions □ Recent fractures (minimum 3 months) □

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

Scar tissues (2 years for major and 6 months for a small scar) □ ……..

Other details:

Muscular/Skeletal problems: Back □……..….. Stiff joints □…..……

Digestive problems: Constipation □ Bloating □ Stomach □ Liver/Gall bladder □

Circulation: Cold hands and feet □ Cellulite □ Tired legs □ Varicose veins □

Kidney problems □ Fluid retention □

Nervous system: Headaches □ Migraine □ Tension □ Stress □ Depression □

Immune system: Sore throat □ Sinuses □ Colds □ Chest □ Prone to infection □

Gynaecological: Menopause □ H.R.T □ P.M.T □ Pills □ Irregular periods □

Coil □ Other □ …… Date of last period: ……..……

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…….

Eating in a hurry □ Regular meals □ Bingeing □ Overeating □

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

Do you smoke? No □ Yes □ average per day: ……...……

Do you drink alcohol? No □ Yes □ average consumption daily/weekly: …..……..……

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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) ……..…

Hobbies/relaxation activities: ……

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

Total contraindication:

Please do not make an appointment if you are aware of any contagious and infectious diseases you suffer as it could spread to other clients coming to the practice. I reserve the right to refuse any treatment to the client suffering illnesses I might believe are harmful to others.

Contagious or infectious diseases □ Fever □ Diarrhoea □

Under the influence of recreational drugs or alcohol □ Vomiting □

Reason for seeking treatment: ……

Client declaration:

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 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.

Client Signature: …….. Date: ……..

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