**Reflexology Consultation Form & Record Card**

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| --- | --- |
| Name: | Phone Number: |
| Address: | DOB: |
| Occupation: | Email: |
| Emergency Contact: | GP Surgery: |

**Health Information**

Are you taking any medications? Yes No

If yes please list name and use:

|  |  |
| --- | --- |
|  |  |

Are you currently pregnant? Yes No (if yes how far along along?………..)

Do you have any allergies or sensitivities? Yes No

Have you any recent injuries? Yes No

If yes, Please list:

|  |  |
| --- | --- |
|  |  |

Please indicate any of the followers contraindications that apply to you.

|  |  |
| --- | --- |
| Cancer | Inflamed nerve |
| Headaches/Migraines | Stroke |
| Arthritis | General circulation or heart |
| Diabetes | Kidney Dysfunction |
| Joint Replacement | Blood Clots |
| High/Low Blood Pressure | Numbness |
| Epilepsy | Sprains or Strains |
| Nervous system dysfunction | Asthma |
| Skin disorders | Gynaecological issues |

Explain any conditions you have ticked above:

|  |
| --- |
|  |

Please rate the following on a scale of 1 (bad) 5 (excellent)

Quality of Sleep 1 2 3 4 5

Energy Levels 1 2 3 4 5

Stress Levels 1 2 3 4 5

Quality of Nutrition 1 2 3 4 5

Daily Fluid Intake 1 2 3 4 5

**Treatment Information**

Have you had Reflexology before? Yes No

Why are you seeking Reflexology today?

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| --- | --- |
|  |  |

Goals for this session?

|  |  |
| --- | --- |
|  |  |

By Signing below, you agree to the following:

I declare that the information that I have given is true and correct and as far as I am aware, I can undertake treatment without any adverse effects. I understand this is not a substitute for medical advice and or treatment .

I………………………………………..confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or Consultant.

Or

I……………………………………….confirm that I have understood the treatment and given my medical history I would prefer to consult with my GP or Consultant prior to receiving the treatment.