Reflexology
Consultation Form

Name:	
Address:	
Telephone Number:	
Email Address:	
Do you wish to be contacted by email about special offers and updates? Yes / No	

Date of Birth:	
Sex: M/F	
Name and Address of GP:	

Profession:	
Marital Status	
Children number and ages:	
Reason for attending reflexology treatments:	

Your health

Have you ever undergone an operation or will you be undergoing surgery (please give details)	
Are you or do you plan to undergo medical tests (please give details)	
Do you take medication (please give details)	
Any other medical history (please give details)	

Contraindications - do you or have you ever suffered from:

Covid-19 Other Contagious Diseases Cellulitis Thrombosis/DVT Phlebitis Aneurism Severe Undiagnosed Headaches Undiagnosed Illness Stroke Gangrene Imminent Medical Tests

Cautions - do you or have you ever suffered from:
Headaches Migraines Anxiety Depression Sinusitis Irritable Bowel Syndrome
Colitis PMT Arthritis Osteoporosis Defective Circulation – cold hands and feet
Heart Condition Varicose Veins High Blood Pressure Low Blood Pressure
Fluid Retention HIV/AIDS Hepatitis Cancer Diabetes Epilepsy Injury to the Feet Verrucae
Thyroidism (hyper or hypo)

Your Lifestyle

Aches and Pains Back Neck Shoulders Knees Stiff Joints Rating of pain out of 10 (10 being the highest):

Stress
How would you rate your stress level on a scale of 1 to 10 (1 being the least stressed):

Sleep
How many hours on average do you sleep per night: Do you feel tired during the day:

Smoking
Do you or have you ever smoked: Yes/No If yes, how many do smoke per day or when did you stop:

Alcohol
Do you drink alcohol: Yes/No If yes, how many units do you drink per week and over how many days:

Exercise
Do you take regular exercise: Yes/No If yes, what type of exercise do you do:

Diet
How would you rate your diet: Poor Average Good Excellent Vegetarian/Vegan:

Water Intake Glasses/litres per day:

Females
Are you pregnant: YES/NO If yes, how many months:

How would you describe your menstruation: normal painful scanty irregular with a change of mood

Are you or have you undergone the menopause:

DECLARATION
I do not suffer from any medical problems other than the ones listed on this form. I agree to undertake the treatment(s) and I will seek medical approval from my GP should the situation with my health change.

I have seen the **online privacy notice** regarding use of my personal information. I understand that you will hold and use my personal information, using it in order to provide me with the best possible treatment options and advice in line with the statements above. I have read the **online Covid-19 advice** had a **Covid risk assessment** (www.relaxheel.co.uk).

Signature:……..

Date:……..