

Consultation Form

Client Note:

The following information is required for your safety and to benefit your health. Whilst holistic therapy is totally safe when administered professionally by a therapist, there are certain conditions which may require special care. The following details will be treated in the strictest of confidence. It may however, be necessary for you to consult your GP.

PLEASE WRITE CLEARLY

Name:		
Telephone No.:		
Address:		Are you happy for me to contact you about future reflexology dates? YES NO
Email:		

Have you had Reflexology before? (please circle) YES NO

Why are you having treatment today?

Are you taking any medication? (please circle) YES NO
If yes, Please list any medication, what you are taking it for and how long you've been taking:

Are you allergic to anything? (please circle) YES NO
Please list any allergies and medical conditions below, state if you could be pregnant, have diabetes, epilepsy, or have any blood conditions such as thrombosis or any heart conditions:

Medical Details:

Name of Doctor: _____ Tel No: _____

Surgery Name & Address: _____

Lifestyle Current Diet:

Breakfast:

Lunch:

Dinner:

Amount of water per day: _____ Amount of cups of Tea/& Coffee: _____

List any Vitamins/Supplements:

Lifestyle:

How much do you smoke? _____

How many units of alcohol do you drink? _____

Current stress levels: (please circle) **High** **Medium** **Low**

Sleep Pattern: (please circle) **Poor** **Average** **Good**

How many hours do you currently sleep?

Exercise currently undertaken:

Hobbies currently enjoying and frequency:

What do you do to Relax and how often?

I declare the above statements to be true *(to the best of my knowledge)*

Please sign for request of treatment.

Client signature:

Date: