

Personal details

Name: _____
 Address: _____
 _____ Postcode: _____
 Occupation: _____
 Doctor: _____
 Practice address: _____
 _____ Postcode: _____

Telephone (day): _____
 Evening: _____
 Mobile: _____
 Email: _____
 Emergency contact: _____
 Telephone: _____
 GP practice tel: _____

General state of health

Do you exercise regularly? Yes No
 Are you taking any medication? Yes No
 Are you on any special diet? Yes No
 Do you smoke? Yes ___ per day No
 Do you drink alcohol? Yes ___ units per week No
 How would you describe your stress levels? High Med Low
 How would you describe your energy levels? High Med Low
 How would you describe your sleep pattern? _____
 What do you do for relaxation? _____
 Have you ever had a reflexology treatment? Yes No
 Reason for treatment? _____

Height: _____
 Weight: _____
 Date of Birth: _____

Female clients only

Could you be pregnant? Yes ___ weeks No
 Are you breastfeeding? Yes No
 Date of last period? _____
 Have you had an IUD fitted in the last 12 weeks?
 Yes No

Conditions and/or symptoms

Do you suffer from any swelling/oedema?	<input type="radio"/> Yes <input type="radio"/> No	Do you have any recent cuts or abrasions?	<input type="radio"/> Yes <input type="radio"/> No
Do you have a mental health condition?	<input type="radio"/> Yes <input type="radio"/> No	Have you recently had any operations?	<input type="radio"/> Yes <input type="radio"/> No
Do you suffer from phlebitis?	<input type="radio"/> Yes <input type="radio"/> No	Have you recently had any inoculations?	<input type="radio"/> Yes <input type="radio"/> No
Do you suffer from any fungal disease e.g. athlete's foot?	<input type="radio"/> Yes <input type="radio"/> No	Have you ever had or do you have cancer?	<input type="radio"/> Yes <input type="radio"/> No
Do you have any verrucas?	<input type="radio"/> Yes <input type="radio"/> No	Do you suffer from any back problems?	<input type="radio"/> Yes <input type="radio"/> No
Do you suffer from unstable blood pressure?	<input type="radio"/> Yes <input type="radio"/> No	Do you have any recent fractures or sprains?	<input type="radio"/> Yes <input type="radio"/> No
Do you suffer from any heart disorders?	<input type="radio"/> Yes <input type="radio"/> No	Are you currently suffering from a fever?	<input type="radio"/> Yes <input type="radio"/> No
Do you have a history of thrombosis/embolism?	<input type="radio"/> Yes <input type="radio"/> No	Do you have diabetes?	<input type="radio"/> Yes <input type="radio"/> No
Do you have epilepsy?	<input type="radio"/> Yes <input type="radio"/> No	Do you have osteoporosis?	<input type="radio"/> Yes <input type="radio"/> No
Do you suffer from any infectious diseases?	<input type="radio"/> Yes <input type="radio"/> No	Do you suffer from arthritis?	<input type="radio"/> Yes <input type="radio"/> No
Do you suffer from any skin disorders?	<input type="radio"/> Yes <input type="radio"/> No	Do you suffer from any allergies?	<input type="radio"/> Yes <input type="radio"/> No
Do you have any severe bruising?	<input type="radio"/> Yes <input type="radio"/> No	Do you suffer from asthmatic conditions?	<input type="radio"/> Yes <input type="radio"/> No
Do you have any recent scar tissue?	<input type="radio"/> Yes <input type="radio"/> No	Have you recently consumed alcohol?	<input type="radio"/> Yes <input type="radio"/> No
Have you recently suffered from a haemorrhage?	<input type="radio"/> Yes <input type="radio"/> No	Have you recently consumed a heavy meal?	<input type="radio"/> Yes <input type="radio"/> No
Do you have any varicose veins?	<input type="radio"/> Yes <input type="radio"/> No	Do you have any other medical condition?	<input type="radio"/> Yes <input type="radio"/> No

Please give details if you answered yes to any of the previous questions:

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Section for use by therapist GP consent required? Yes No Verbal consent obtained? Yes* No *(client to sign and date declaration below)
 Written consent obtained? (attach) Yes* No

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Client declaration: I declare the information that I have given is true and correct and that, as far as I am aware, I can undertake treatment with this establishment without any adverse effects. I have been fully informed about contra-indications and am willing, therefore, to proceed. I understand that reflexology is not a substitute for medical advice and/or treatment.

Client's signature:

Date:

Therapist's signature:

Date: