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| **Consultation Form Reflexology Level 5 – 2021/2022 GROUP 1** | |
| Clients Name:  DOB:  Telephone Number:  Email: | Address: |
| Gender: |
| Occupation: |
| GP Name:  GP Address:  GP informed of treatment? | Emergency Contact Name:  Emergency Contact Number: |
| **Contraindications**:  Thrombosis / DVT / Unstable heart condition / Imminent medical Test (total)  Drugs or alcohol / Contagious or Notifiable diseases (total)  Varicose Veins severe / Verrucae and Warts / Phlebitis / Cellulitis / Injury to feet (local) | I am pregnant or trying to get pregnant.  I have discussed the possibility of miscarriage and have been advised by the practitioner that there is no evidence to suggest that having reflexology can provoke a miscarriage and I am willing to go ahead with the treatment at my own risk |
| **Medical History** | |
| Have you had any conditions associated with your head? eg headaches, migraines, vertigo, any surgery to the head? | |
| Have you any problems or conditions with your heart? eg Varicose veins, heart problems, high or low blood pressure, bruising, Anaemia, circulation problems (cold hands/feet or sweating and too hot), Cholesterol? | |
| Do you have any conditions associated with your senses? eg hearing, vision, balance, Tinnitus, taste disturbance? | |
| Do you have any issues with your digestive system? eg Constipation, Diarrhoea, IBS, stomach ulcers, heartburn, Pancreatitis, Diabetes, gall-stones, Liver problems? | |
| Do you suffer from frequent infections? Or anything associated with your Lymphatic system? eg swollen glands, Tonsillitis, tiredness, Lymphoedema? | |
| Do you suffer from any issues with erectile dysfunction, testicular, fertility, Prostate? | |
| When was your last menstrual period? Are you pregnant? Have you been through menopause?  Tell me about previous pregnancies, miscarriages, Fertility, unexplained, IVF, ICSI, and IUI? | |
| Do you suffer from any respiratory conditions? eg shortness of breath, Sinus, Emphysema, Bronchitis, Asthma/COPD, cold/flu? | |
| Do you have any muscular issues? eg Arthritis/Osteo/ Rheumatoid, muscle pains, gout, Osteoporosis, back problems? | |
| Do you have any issues affecting your joints or muscles? eg Hand disorders, repetitive sprain, fractures, Aches/pains? | |
| Have you had any Surgery? Please specify. | |
| Do you have any issues with kidneys or bladder? eg UTI Infections, bladder infections, Cystitis, kidney stones, pain passing urine? | |
| Do you have any skin conditions? eg Eczema, acne, Psoriasis, dry, prickly heat, Allergies? | |
| Do you suffer with anxiety or a stress-related disorder?  Do you have any issues with your nervous system? eg MS, ME, depression, Epilepsy, Neuropathy, anxiety, fatigue? | |
| Do you have any known issues with hormonal imbalances? eg Thyroid, stress, mood, problems with sleep? | |
| Have you had cancer or are having treatment for cancer? eg Breast, skin, prostrate, bowel? | |
| Do you have any issues with your feet? eg Verrucae, corns, warts, nail infections, fallen arches? | |
| Are you currently under care of a Doctor or Hospital Consultant? | |
| Have you had Covid -19 Y / N When?  Have you symptoms of long covid? Specify | |
| Are you currently taking medication/supplements? Please specify: | |
| **Lifestyle** | |
| Do you smoke/vape Y / N If so how many?  Do you drink alcohol? If so how much?  Daily  Weekly  Occasionally  Non-Drinker  Do you exercise? How often?  What is your daily fluid intake?  Do you have any dependents? | Do you sleep well?  Smiling face outline with solid fillPoor Moderate Good  Tired face outline with solid fillOn a scale of 0 – 10 how stressed are you?  On a scale of 0-10 how much pain do you have?  Sad face outline with solid fill  Smiling face outline with solid fillOn scale 1 -6 how do you rate your wellbeing?  Have you had reflexology before? |
| I declare that all information given on this consultation form is, in all respects, complete, true and correct to the best of my knowledge. I understand and consent to undergo Reflexology treatments, based on the explanation I have received and the medical information I have provided above. My preferred contact - email, phone, text, mail. The information provided here is to allow the therapist to contact me re appointments etc. My information will be stored confidentiality and not shared with anyone else ie GP without my expressed consent in writing.  Completed by: Self / Parent / Guardian  Signature………….……………………………......................................................................................  Date…............…/…...........…/……..............  Under GDPR this information will be retained securely by the therapist and it will be held for 8 years as per recommendations of my insurance company. Privacy notice is available to see at your request. | |
| How did you hear about me? | |