**Consultation Form Reflexology Level 5 - 2021/2022 – Group 2**

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| Clients Name: | GP Name: |
| Address:  Tel: DOB:  Gender:  Email:  Occupation FT/PT:  Emergency contact/Name:  Do you have any dependants? YES / NO | Address:    Tel:  Are you under hospital care? YES NO  What for? |
| Please rate the following on a sale of 1-5 – five being excellent  Quality of Sleep 1 2 3 4 5 Hours per night …………  Energy Levels 1 2 3 4 5  Stress Levels 1 2 3 4 5  Quality of nutrition 1 2 3 4 5  Exercise Habits 1 2 3 4 5  Water Intake 1 2 3 4 5 How much daily ………….. | Any special dietary conditions? YES NO  Explain:  Any allergies or skin conditions? Yes No  Explain: |
| □ Smoker how many 1 – 10 □  11 – 20 □  20+ □  □ Non smoker/Ex-smoker  □ Vape  □ Patches | Alcohol intake:  Non Drinker □  Units consumed  Occasionally …………………………….  Daily ……………………………..  Weekly ……………………………..  *Units:*  *Pint of standard beer 4% 568ml = 2.3 units*  *Beer 5% 330ml = 1.7 units*  *Wine 175ml glass = 2.3 units*  *Spirits 40% single = 1 unit* |
| Medication/ Supplements:  None | |
| Have you had Reflexology before? No If yes, what type of pressure light / moderate / firm  What do you wish or are hoping to achieve from your Reflexology today?  Do you receive any other forms of complimentary therapies? | |
| **Contraindications:**  Thrombosis/DVT (Total) **Yes/No**  Unstable heart condition (Total) **Yes/No**  Imminent medical Test (Total) **Yes/No**  Drugs or alcohol (if lacking coping skills total) **Yes/No**  Contagious or Notifiable diseases (Total) **Yes/No**  Varicose Veins severe (local) **Yes/No**  Verrucae and Warts (local) **Yes/No**  Phlebitis/Cellulitis (local) **Yes/No**  Injury to feet (local) **Yes/No** | **GP / Health Professional Consent:**  On warfarin meds  Diabetes if unstable  Epilepsy  Osteoporosis  Aneurism  Cancer  Surgery / Recent Surgery – Please note………………….  …………………………………………………………………………………………..  ………………………………………………………………………………………….. |

**Do you have/or have you ever suffered from any of the following: (PLEASE TICK)**

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| **Head** | Headaches | | Migraines | | Head injury | | | | |  | | | | | | | |
| **Senses** | Hearing | | Vision | | Balance | | | | | Smell | | Tinnitus | | Taste | |  | |
| **Lymphatic** | Glands Swelling | | Tonsillitis | | Frequent Infections | | | | | Tiredness | | Lymphoedema | |  | | | |
| **Circulatory/Cardio-Vascular** | Varicose veins | | Blood Pressure  High/Low | | Heart problems | | | | | Circulation- Feet cold or hot and stuffy | | Anaemia | | Bruising | |  | |
| **Digestive** | Heartburn | | Stomach Ulcers | | Constipation or Diarrhoea | | | | | Liver problems | | IBS | | Candida | | Gallstones | |
| **Male Reproductive** | Prostate | | Testicular | | Erectile Dysfunction | | | | | Fertility | |  | | | | | |
| **Female Reproductive** | Menstrual cycle Are you Pregnant? Yes No | | | | | | | | | Peri menopausal | | Post-menopausal | | PCOS | | Endometriosis | |
| Pregnancies | Miscarriages | | | | Hysterectomy | | | | | Fertility  unexplained | | IVF | | ICSI | | IUI | |
| **Respiratory** | Sinus | | Cold/Flu | | Ear Infections | | | | | Asthma/COPD | | Bronchitis | | Shortness of Breath | | Emphysema | |
| **Muscular** | Aches/pain | | Muscles Joints | | Sprains | | | | | Back problems | | Strains | |  | | | |
| **Skeletal** | Aches/pains  Bones | | Hand disorders | | Fractures | | | | | Osteoporosis | | Arthritis/Osteo/  Rheumatoid | | Gout | | Tendonitis | |
| **Urinary** | Cystitis | | UTI Infections | | Kidney Infections | | | | | Diabetes  T1 or T2 | | Pain/pressure urinating | |  | | | |
| **Skin** | Allergies | | Eczema | | Acne | | | | | Inflammation swelling | | Dry | | Psoriasis | | Athletes Foot | |
| Verrucae | | Nail Infections | | Corns | | | | | Warts | |  | | | | | |
| **Nervous System** | Depression | | Fatigue | | Anxiety | | | | | Epilepsy | | ME | | MS | | Neuropathy | |
| Fibromyalgia | | | | | | | | |  | | | | | | | |
| **Endocrine** | Thyroid | | | Moods | | | Stress | | |  | | | | | | | |
| **Cancer** | Breast | | | Lung | | | Colon | | | Prostrate | | Other | |  | | | |
| **Foot Disorders** |  | | | | | | | | | | | | | | | | |
| **Covid** | Have you had covid: Yes / No Date: Diagnosed with long covid? Yes / No Date: | | | | | | | | | | | | | | | | |
| **Any other Conditions** |  | | | | | | | | | | | | | | | | |
| **Do you have any family history?** | Diabetes | Epilepsy | | | | Heart Disease | | Skin Conditions | | | Arthritis | | Asthma | | Bowel | | Hypertension |
| Other comment: | | | | | | | | | How did you hear about me? | | | | | | | | |
| I am pregnant or trying to get pregnant. I have discussed the possibility of miscarriage & have been advised by the practitioner that there is no evidence to suggest that having reflexology can provoke a miscarriage & I am willing to go ahead with the treatment at my own risk. □ Please tick if applicable  I declare that all information given on this consultation form is, in all respects, complete, true & correct to the best of my knowledge. I understand & consent to undergo Reflexology treatments, based on the explanation I have received & the medical information I have provided above. Under GDPR this information will be retained securely by me & it will be held for 8 years as per recommendations of my insurance company. Privacy notice is available to see at your request.  Completed by: Self / Parent / Guardian  Signature Date | | | | | | | | | | | | | | | | | |