**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 NOWhat 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 NOExplain: 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 / firmWhat 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 unstableEpilepsyOsteoporosis AneurismCancerSurgery / Recent Surgery – Please note………………….…………………………………………………………………………………………..………………………………………………………………………………………….. |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 PressureHigh/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 | Fertilityunexplained | 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/painsBones | Hand disorders | Fractures | Osteoporosis | Arthritis/Osteo/Rheumatoid | Gout | Tendonitis |
| **Urinary** | Cystitis | UTI Infections | Kidney Infections | DiabetesT1 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 applicableI 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 |