Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| To be checked and signed by client  at every Reflexology Treatment |

**Pregnancy Check List**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Treatment |  |  |  |  |
| Gestation (weeks) |  |  |  |  |
| Gestational Diabetes |  |  |  |  |
| Blood Pressure Note last BP result (oedema/proteinuria |  |  |  |  |
| Vaginal Bleeding |  |  |  |  |
| Headaches – note location: temple, frontal any Visual disturbances |  |  |  |  |
| Epigastric pain |  |  |  |  |
| Abdominal pain |  |  |  |  |
| Visual Disturbances |  |  |  |  |
| Calf pain/swelling/heat/redness |  |  |  |  |
| Breathlessness |  |  |  |  |
| Abnormal itching of palms/feet |  |  |  |  |
| Excessive oedema |  |  |  |  |
| Cystitis /Urinary Tract Infection |  |  |  |  |
| Is your baby movement normal for you |  |  |  |  |
| Placenta conditions |  |  |  |  |
| **Signature of Client** |  |  |  |  |