SET 1 CONSULTATION FORM

To be completed by the Reflexology Learner and signed by the case study client

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| **TITLE:** | **NAME:** | | | | | |
| **DATE OF BIRTH:** | **SEX:** MALE/FEMALE | | | | | **OCCUPATION:** |
| **ADDRESS:** | | | | | | **POSTCODE:** |
| **CONTACT TEL NOS:** | | | **EMAIL:** | | | |
| **CLIENT’S CONDITION/S :**  **ORIGIN:**  **WHAT MAKES IT/THEM WORSE:**  **WHAT RELIEVES THE CONDITION/S:** | | | | | | |
|  | | YES | | NO | DETAILS:- | |
| 1. Are you Taking any medication? | |  | |  | If yes, what for? | |
| 2. Do you have any contagious disease? | |  | |  |  | |
| 3. Are you allergic to any medicines, foods or materials? | |  | |  |  | |
| 4. Pregnant or planning to become  pregnant? | |  | |  |  | |
| 5. Do you have thrombosis, or are receiving medication for this condition? | |  | |  |  | |
| 6. Are you exposed to stressful situations? (i.e., work, noisy neighbours, family). | |  | |  |  | |
| 1. Had any cardio-vascular disorders? i.e. angina or unstable heart condition? | |  | |  |  | |
| **\* If your client is suffering from the following conditions, Reflexology may be inappropriate at this time – use caution, contact your Tutor, if in doubt do NOT treat:**  **Thrombosis (including D.V.T’s), Embolus, Phlebitis, Unstable heart condition, Shingles (while pustules are present) or during the first 3 months of pregnancy.**  **PROVIDE ANY OTHER RELEVANT DETAILS.** | | | | | | |
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| 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.  Completed by: Self / Parent / Guardian  Signature………….…………………………… Date……/……/…… | | | | | | |

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| Treatment **SOAP** Notes - Study Client ID: | | | | | | | |
| Date: |  | Start time: |  | Finish time: |  | Treatment number: |  |
| Preferences:  Depth of Touch: Light Medium Deep Varies  Music: Yes / No  Reclining position / postural support:  Infection prevention / Allergies  Psychological & relevant information between treatments:  Need for referral? | | | | | Measurements:  MYCAW Yes / No  Pain: 1 2 3 4 5 6 7 8 9 Detail:  Stress: 1 2 3 4 5 6 7 8 9 Detail: | | |

**Subjective:** (why they came for a treatment, what they say, what are they experiencing, what makes things better / worse)

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| Study Client symptoms and goals:  Other: |

**Objective:** (what I see / observe / find)

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| Visual: |
| Tactile: |
| Areas of Focus: |
| System/s focus: |
| Other: |

**Assessment:** (what happened / what changed)

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| Preparatory Techniques: |
| Treatment Responses + interpretation/relevance: |
| Study Client Responses: |
| Other: |

**Plan:** (future treatments / techniques / focus / self-care suggestions)

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| Number of Treatments recommended: | Date of next treatment: |
| Techniques for next treatment and reasons: | |
| Plan for Self-Care/support between treatments: | |
| Other: | |