

# Consultation Form

Title \_\_\_\_\_ First Name \_\_\_\_\_ Family Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Fema ☐ ☐

Email \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Doctors Name \_\_\_\_\_ Surgery Telephone \_\_\_\_\_

Surgery Address \_\_\_\_\_

## Medical information

If you have any health condition (whether or not listed below) we recommend that you proceed only with your doctor's approval.

- |                                                |                                              |                                            |                                          |                                                  |
|------------------------------------------------|----------------------------------------------|--------------------------------------------|------------------------------------------|--------------------------------------------------|
| <input type="radio"/> Heart conditions/Strokes | <input type="radio"/> Kidney/Liver disorders | <input type="radio"/> Joint problems       | <input type="radio"/> Multiple sclerosis | <input type="radio"/> Product allergies          |
| <input type="radio"/> Cancer/Chemotherapy      | <input type="radio"/> Thyroid problems       | <input type="radio"/> Osteoporosis         | <input type="radio"/> IBS                | <input type="radio"/> Skin sensitivity/Allergies |
| <input type="radio"/> Secondary Lymphoedema    | <input type="radio"/> Poor circulation       | <input type="radio"/> Osteoarthritis       | <input type="radio"/> Crohns disease     | <input type="radio"/> Hormonal imbalance         |
| <input type="radio"/> High/Low blood pressure  | <input type="radio"/> Recent operations      | <input type="radio"/> Rheumatoid arthritis | <input type="radio"/> Muscular pain      | <input type="radio"/> Psoriasis/Eczema           |
| <input type="radio"/> Diabetes (Type 1 or 2 )  | <input type="radio"/> IVF/Breast feeding     | <input type="radio"/> Chronic fatigue      | <input type="radio"/> Asthma             | <input type="radio"/> Foot infections            |
| <input type="radio"/> Epilepsy                 | <input type="radio"/> Depression/Anxiety     | <input type="radio"/> Fibromyalgia         | <input type="radio"/> Varicose veins/DVT |                                                  |
| <input type="radio"/> Hepatitis                | <input type="radio"/> Water retention/Oedema | <input type="radio"/> Lupus                | <input type="radio"/> Thrombosis         |                                                  |

If you have selected any of the above health conditions, please provide more information here:

Are you taking any medication or homeopathic supplements?

## Specific hormonal concerns

Do you suffer from any of the following:

- |                                           |                                         |                                          |                                           |                                                  |
|-------------------------------------------|-----------------------------------------|------------------------------------------|-------------------------------------------|--------------------------------------------------|
| <input type="radio"/> Irregular periods   | <input type="radio"/> Mood swings       | <input type="radio"/> Sleep disturbances | <input type="radio"/> Backache            | <input type="radio"/> Morning sickness or nausea |
| <input type="radio"/> Heavy periods       | <input type="radio"/> Irritability      | <input type="radio"/> Memory fog         | <input type="radio"/> Neck ache           | <input type="radio"/> Heartburn                  |
| <input type="radio"/> No menstruation     | <input type="radio"/> Stress            | <input type="radio"/> Digestive issues   | <input type="radio"/> Other skeletal pain | <input type="radio"/> Hot flushes                |
| <input type="radio"/> Ovulation pain      | <input type="radio"/> Bloating          | <input type="radio"/> Constant fatigue   | <input type="radio"/> Haemorrhoids        | <input type="radio"/> Night sweats               |
| <input type="radio"/> Headaches/migraines | <input type="radio"/> Breast tenderness | <input type="radio"/> Acne               | <input type="radio"/> Constipation        |                                                  |

Date of last menstruation \_\_\_\_\_ Next period due date \_\_\_\_\_ Normal length of menstruation \_\_\_\_\_

Could you be pregnant? \_\_\_\_\_ If yes, how many weeks pregnant are you? \_\_\_\_\_

What is your due date? \_\_\_\_\_ Are there any complications with your pregnancy? Yes ☐ no ☐

If yes, please explain \_\_\_\_\_

Have you been through the menopause in the last 2 years? Yes ☐ no ☐

If yes, when was your last menstruation? \_\_\_\_\_

Are you in pain? Yes ☐ no ☐

If yes, please explain \_\_\_\_\_

## General Health and Wellbeing

Please be as honest as possible when answering the following questions, they might not seem relevant to your session, but they provide me with a really good understanding about your everyday life and how I can possibly support you with useful health and wellbeing advice.

Please select the number which best represents your general health and wellbeing? How do you feel in yourself?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

As good as it could be

As bad as it could be

Please provide more information as to why you chose that particular number? \_\_\_\_\_

## Stress

Please select the number which best represents your current stress levels.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

As good as it could be

As bad as it could be

Do you have any coping mechanisms or ways to effectively manage your stress? \_\_\_\_\_

## Sleep

Please score your sleep based on the following:

0 - Never or rarely    1 - Occasionally    2 - Almost always

1. Refreshed - Do you wake up feeling refreshed? \_\_\_\_\_

2. Alarm - Do you wake at the same time (within 30 minutes) everyday without an alarm? \_\_\_\_\_

3. Time Elapsed? Do you fall asleep within 30 minutes? \_\_\_\_\_

## Exercise

What type of exercise do you enjoy? \_\_\_\_\_

How frequently and for how long do you exercise?

Frequency (Weekly)                      0, 1, 2, 3, more than 4 times \_\_\_\_\_

Length of exercise (Minutes)            10, 20, 30, 40, 50, 60, more than an hour \_\_\_\_\_

## Diet

Please briefly describe an average day of eating:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Supper \_\_\_\_\_

Snacks \_\_\_\_\_

How much water do you consume each day? \_\_\_\_\_ pints

How many cups of caffeinated drink do you consume daily? 1, 2, 3, 4, other \_\_\_\_\_

What is your weekly alcohol consumption? (2-3 units = 1-2 glasses 8-11 units = 1 bottle of wine) \_\_\_\_\_

Please write down one or two concerns or problems which you would most like me to help with?

1. \_\_\_\_\_

2. \_\_\_\_\_

Please select a number to show how severe each concern or problem is now:

Concern or problem 1:

0 ☐

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

As good as it could be

As bad as it could be

Please provide more information as to why you chose that particular number? \_\_\_\_\_

Concern or problem 2:

0 ☐

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

As good as it could be

As bad as it could be

Please provide more information as to why you chose that particular number? \_\_\_\_\_

Is there anything else you think I should know regarding your health that may affect or prevent you having treatment?

## Your Permission

In line with the new General Data Protection Regulation (GDPR) as of May 2018, I ask you to complete a consultation form to allow me to have your address, telephone number and email address in case I need to contact you in relation to your appointments. I also need to know a bit about your lifestyle and medical history, and why you would like to book a reflexology treatment with me. This will allow me to make sure that I personalise the treatment to give you the best possible outcome. Anything you tell me is in the strictest of confidence, I never share it with anyone, and make sure printed information is stored under lock and key, and electronic is password protected on my computer. I like to keep my records for 7 years for insurance reasons, but you can ask me to destroy or delete your personal information at any time. If you have any questions regarding this, please just email or phone me directly.

Client signature (1st visit) \_\_\_\_\_ Date \_\_\_\_\_

Please select here if you do not wish to receive future promotional or event mailings: ☐

## for reflexologists use only

Date: \_\_\_\_\_ Reflexologist: \_\_\_\_\_ Treatment: \_\_\_\_\_

Treatment notes and plan: