CONFIDENTIAL CLIENT CONSULTATION FORM

Name: **Address:** **Tel No:** **Email:**	**GP's Name:** **Tel No:** **Age group: under 20 ( ) 20-30 ( ) 30-40 ( ) 40-50 ( ) 50-60 ( ) 60+ ( )**
Health Information: **Do you have any areas of pain now?**	
Medication: **Side effects of medication:**	

LIFESTYLE	
Ability to relax? Good ( ) Moderate ( ) Poor ( ) **Sleep patterns: Good ( ) Poor ( ) Average number of hours ( )**	
How is your diet? **What do you drink in a day?**	
Do you smoke No ( ) Yes ( ) How many per day? **Do you drink alcohol No ( ) Yes ( ) How many units per day?**	
How often do you exercise? None ( ) Occasionally ( ) Irregular ( ) Regular ( ) **Describe the type of exercise you do:**	
What is your skin type **Dry ( ) Oily ( ) Combination ( ) Sensitive ( ) Dehydrated ( )** **Are you allergic to any types of medium (eg: oil, powder, balm)** **Are you allergic to any types of products? Or smells?** **Do you suffer/have you suffered from:** **Dermatitis ( ) Acne ( ) Eczema ( ) Psoriasis ( ) Allergies ( ) Hay Fever ( ) Asthma ( ) Skin Cancer ( )**	
Stress Levels from 1- 10 (10 being the highest) **At work:** **At Home:**	

How can I help you with reflexology?   **Any other relevant information?**

CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment *(select where/if appropriate):*			
Pregnancy		Slipped disc	
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)		Bell's Palsy	
Any condition already being treated by a GP or another complementary practitioner		Postural deformities	
Medical oedema		Diabetes	
Osteoporosis		Asthma	
Arthritis		Any disfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease)	
Nervous/Psychotic conditions		Trapped/Pinched nerve (e.g. sciatica)	
Epilepsy		Inflamed nerve	
Recent operations		Cancer	
Undiagnosed pain		Spastic conditions	
Taking prescribed medication		Kidney infections	
Whiplash		Acute rheumatism	

CONTRAINDICTIONS THAT RESTRICT TREATMENT *(select where/if appropriate)*:			
Fever		Conditions affecting the neck	
Contagious or infectious diseases		Menstruation	
Under the influence of recreational drugs or alcohol		Cuts	
Diarrhoea and vomiting		Bruises	
Pregnancy (first trimester)		Abrasions	
Skin diseases		Scar Tissue (2 years for major operation; 6 months for a small scar)	
Localised swelling		Sunburn	
Inflammation		Haematoma	
Varicose veins		Recent Fracture (minimum 3 months)	

Informed Consent Disclaimer

Please read carefully and only sign if you are in full agreement with its contents

I *(insert name)* confirm that I have understood the reflexology treatment that I am to receive and confirm that I am happy to proceed with the treatment without confirmation from my own GP or Consultant.

How your information will be used. I take your privacy seriously and your personal information will only be used for treatment purposes and will never be shared with any third parties, without express permission.

From time to time I would like to get in touch with you when I have information about special offers that I think maybe of interest to you. If you agree please tick are happy to be contacted ( ). If you have ticked a box please note that you can change your mind and remove your consent at any time by contacting me.

By signing below, you agree that the information in this form is true and accept that it is your responsibility to keep the therapist updated regarding any changes in your health, wellbeing, or medication.

You hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment.

Client's Signature: **Date**