

**CONFIDENTIAL CLIENT CONSULTATION FORM**

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| --- | --- |
| **Name:** | **Date of treatment:** |
| **Address:****Email:** | **Telephone Number:** |
| **Health Information:** |
| **Medication:****Any side effects:** |
| **CAUTION CHECK:** |
|

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Acute undiagnosed pain (refer to GP/A&E)** | **Y** | **N** | **Any heart or blood pressure issues?** | **Y** | **N** |
| **Allergies** | **Y** | **N** | **Varicose veins/phlebitis in treatment areas** | **Y** | **N** |
| **Diabetes** | **Y** | **N** | **Imminent medical tests or procedures** | **Y** | **N** |
| **Epilepsy** | **Y** | **N** | **Recent Surgery** | **Y** | **N** |
| **Osteoporosis**  | **Y** | **N** | **Injury or condition linked to area of work** | **Y** | **N** |
| **If you have answered yes to any of the above please give details:** |
| **Note on contraindications that restrict treatment:** |
| **Please note that the following are contraindicated conditions:** **Cellulitis where you are working over the area, fever or contagious illness, deep vein thrombosis or pulmonary embolism or diarrhoea and vomiting or pregnancy (first trimester) or skin diseases or clients that are under the influence of drugs or alcohol.** |

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| **Do you have any areas of pain now?** |  |
| **Date of last period/how are your periods?** |  |
| **How is your diet?** |  |
| **What do you drink in a day?**  |  |
| **Bowel and urinary health?** |  |
| **Smoking/alcohol** |  |
| **Do you exercise?** |  |
| **Do you find it easy to relax and how do you relax?** |  |
| **Describe your sleep pattern.** |  |
| **How would you rate your energy levels?** |  |
| **How would you rate your stress levels?** |  |
| **Are you allergic to any types of medium ? (e.g.: oil, powder, balm)** **Are you allergic to any types of products? Or smells?**  |
| **How can I help you with reflexology?** |
| **Any current symptoms?** |
| **Any other relevant information?** |
| **Any questions or concerns?** |

INFORMED CONSENT DISCLAIMER

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

I *……………………………………………….*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.

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

You hereby indemnify Hand on Sole Reflexology LTD against any adverse reaction sustained as a result of the treatment.

**Client’s Signature: Date:**