Reflexology Consultation Sheet

Date		Visit number	

Clients name	Doctors name
Clients address Telephone	Doctors address Telephone

D.O.B.	Height	Weight

Occupation	Reason for visit

Marital status (delete as applicable) Married / Single / Separated / Divorced / Widowed

Number of children	Pregnant Yes / No If yes, for how long?

Cigarettes Yes / No If yes, how many per day? 1-10/10-20/20-30/30-40/40+

Alcohol Yes / No If yes how many units on average per week

Medication (including HRT and birth control), Self medication/Vitamins etc.

Other therapies/treatments being undertaken

Diet Poor / Average / Good	Regular meals Yes / No
Fluid intake Poor / Average / Good	Food supplements Yes / No

State of health at present	Major illness
Major operations	Accidents/Injuries/physical handicaps

Personality	Energy levels

Regular exercise Yes / No. If yes in what form

Sleep patterns	Good / Average / Poor	hrs daily

Stress /10	Anxiety /10	Depression /10

Glasses Yes / No	Lens Yes / No	Hearing aid Yes / No

Do you or a close relative suffer from any of the following conditions

Epilepsy	Diabetes	Blood pressure
Thrombosis	Kidney/Bladder	Sinus/Ear
Migraine	Heart/Chest	Varicose Veins
Allergies	Digestive/Bowel	Skin problems
P.M.S.	Asthma	Cancer
Headaches	Back problems	Arthritis

Regular Periods Yes / no	Date of last period

Condition of feet	Right Foot	Left Foot
Colour		
Skeletal Condition		
Muscle tone/flexibility		
Flat foot/high arch		
Nail & Skin condition		
Hard skin build up		
Temperature		
Position of foot fall		
Distinguishing marks/scars		

I, the undersigned agree that the information above is to the best of my Knowledge accurate and true and I hereby give my consent to the therapist named below to carry out Reflexology treatments upon me.

Client Signature

Therapists Signature

Lynda Bowen Aomatherapy I.T.E.C (dip, A & R) T.A.Th.
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