CONSULTATION DETAILS

Client's Name: **Address:** **Tel No:** **Email:** **D.O.B:**	**GP Name:** **Clinic Address:** **Tel No:**

Occupation:

Medical History: (illnesses, diseases, disorders, accidents, injuries, operations etc.)

Medication: (past and present, duration)	**Allergies:**

Presenting Conditions: (reasons for Reflexology)

LIFESTYLE

Diet: (typical daily intake, fluids & supplements)

Smoke / Alcohol Consumption:

Stress Levels / Worries and Fears:

SYSTEM REVIEW (FOR HOLISTIC HEALING TO COMPLETE)

Skin:	**Skeletal:**
Muscular:	**Nervous:**
Circulatory:	**Lymphatic:**
Respiratory:	**Glandular:**
Reproductive:	**Renal:**
Digestive:	

FOR THE CLIENT TO COMPLETE

Details of previous Reflexology/other Complementary treatments:

	No	Yes
For women - are you in the first 3 months of pregnancy	☐	☐

	No	Yes		No	Yes
Diabetes	☐	☐	Asthma	☐	☐
High blood pressure	☐	☐	Trapped/pinched nerve	☐	☐
Low blood pressure	☐	☐	Epilepsy	☐	☐
Heart conditions	☐	☐	Nervous system dysfunction	☐	☐
Blood conditions	☐	☐	Whiplash	☐	☐
Cancer	☐	☐	Acute rheumatism	☐	☐
Osteoporosis	☐	☐	Arthritis	☐	☐

Disclaimer

For my records, I need to confirm that you have read, understood and answered all of the previous questions. Otherwise, please read the following and sign below:

To the best of my knowledge, the information I have given is true and I have not withheld any information concerning my health. I will keep Holistic Healing updated on my health, should there be any changes to the answers given above. I understand that there is a possibility that I may experience some minor reactions as my body adjusts to the treatment.

I understand that a Reflexologist does not diagnose illness, disease or any other physical or mental condition. I understand that this treatment is not a substitute for medical examination, diagnosis or treatment. While I recognise that all due care will be taken by the therapist, I am aware that my participation in the treatment is voluntary.

The information used on this consultation sheet is treated with the strictest confidence. Any treatment carried out by is performed with your agreement and at your own risk.

Client _____ Date _____