PRIVATE AND CONFIDENTIAL

NAME:

CONSULTATION SHEET

Reflexology

NAME:

ADDRESS:

TEL:

DOB

DOCTOR ADDRESS:

MEDICAL HISTORY:

CHILDREN/PREGNANCIES/PREGNANT

ACCIDENTS/ILLNESSES/OPERATIONS

Cancer

Heart problems

Blood clot / thrombosis

Allergies

Sprains or strains to feet or ankles

Previous operations to feet or ankles

Asthma / eczema

Diabetes

Spinal problems

Headaches

Medication

Blood pressure

Digestive/bowels/urinary

(regular/irregular/constipation/bloated etc)

Periods/menopause (regular/irregular)

MEDICATION

LIFESTYLE:

Occupation

Exercise

Smoke

Alcohol

Diet

Tea/coffee

Water

Sleep well

REASON FOR COMING

Any other matters or related subjects

I AM SIGNING TO SAY THAT I HAVE INFORMED TERESA OF ALL KNOWN HEALTH ISSUES

PLUS THAT I HAVE HAD THE PRIVACY POLICY EXPLAINED TO ME AND HAVE BEEN OFFERED A COPY

NAME……..

SIGNATURE……

DATE……