

## Personal Details

Name:	Client No.:
Address:	Telephone (including code)
Postcode:	Day: <input type="text"/>
Occupation:	Evening: <input type="text"/>
Doctor:	Mobile: <input type="text"/>
Practice Address:	Practice: <input type="text"/>
Postcode:	

## General State of Health

Do you exercise regularly? <input type="radio"/> no <input type="radio"/> yes	Are you taking any medication? <input type="radio"/> no <input type="radio"/> yes	Are you on any special diet? <input type="radio"/> no <input type="radio"/> yes	Height: <input type="text"/>
How would you describe your stress levels? <input type="radio"/> high <input type="radio"/> medium <input type="radio"/> low	How would you describe your energy levels? <input type="radio"/> high <input type="radio"/> medium <input type="radio"/> low	Weight: <input type="text"/>	Female clients:
Do you smoke? <input type="radio"/> no <input type="radio"/> yes, <input type="text"/> cigarettes per day	Do you drink alcohol? <input type="radio"/> no <input type="radio"/> yes, <input type="text"/> units per week	Could you be pregnant? <input type="radio"/> no <input type="radio"/> yes, <input type="text"/> months	Are you breast feeding? <input type="radio"/> no <input type="radio"/> yes
How would you describe your sleep patterns?	What do you do for relaxation?	Date of last period? <input type="text"/>	Have you had an IUD fitted in the last 12 weeks? <input type="radio"/> no <input type="radio"/> yes
Have you ever had a massage treatment? <input type="radio"/> no <input type="radio"/> yes	Reason for treatment?		

## Conditions and/or Symptoms

Do you suffer from any swelling/oedema? <input type="radio"/> no <input type="radio"/> yes	Have you recently consumed alcohol? <input type="radio"/> no <input type="radio"/> yes
Do you have a mental health condition? <input type="radio"/> no <input type="radio"/> yes	Have you recently consumed a heavy meal? <input type="radio"/> no <input type="radio"/> yes
Do you suffer from phlebitis? <input type="radio"/> no <input type="radio"/> yes	Do you have any other medical condition? <input type="radio"/> no <input type="radio"/> yes
Do you suffer from any fungal disease e.g. athlete's foot? <input type="radio"/> no <input type="radio"/> yes	
Do you have any verrucas? <input type="radio"/> no <input type="radio"/> yes	
Do you suffer from unstable blood pressure? <input type="radio"/> no <input type="radio"/> yes	
Do you suffer from any heart disorders? <input type="radio"/> no <input type="radio"/> yes	
Do you have a history of thrombosis/embolism? <input type="radio"/> no <input type="radio"/> yes	
Do you have epilepsy? <input type="radio"/> no <input type="radio"/> yes	
Do you suffer from any infectious diseases? <input type="radio"/> no <input type="radio"/> yes	
Do you suffer from any skin disorders? <input type="radio"/> no <input type="radio"/> yes	
Do you have any severe bruising? <input type="radio"/> no <input type="radio"/> yes	
Do you have any recent scar tissue? <input type="radio"/> no <input type="radio"/> yes	
Have you recently suffered from a haemorrhage? <input type="radio"/> no <input type="radio"/> yes	
Do you have any varicose veins? <input type="radio"/> no <input type="radio"/> yes	
Do you have any recent cuts or abrasions? <input type="radio"/> no <input type="radio"/> yes	
Have you recently had any operations? <input type="radio"/> no <input type="radio"/> yes	
Have you recently had any inoculations? <input type="radio"/> no <input type="radio"/> yes	
Have you ever had or do you have cancer? <input type="radio"/> no <input type="radio"/> yes	
Do you suffer from any back problems? <input type="radio"/> no <input type="radio"/> yes	
Do you have any recent fractures or sprains? <input type="radio"/> no <input type="radio"/> yes	
Are you currently suffering from a fever? <input type="radio"/> no <input type="radio"/> yes	
Do you have diabetes? <input type="radio"/> no <input type="radio"/> yes	
Do you have osteoporosis? <input type="radio"/> no <input type="radio"/> yes	
Do you suffer from arthritis? <input type="radio"/> no <input type="radio"/> yes	
Do you suffer from any allergies? <input type="radio"/> no <input type="radio"/> yes	
Do you suffer from asthmatic conditions? <input type="radio"/> no <input type="radio"/> yes	

Please give details if answered yes to any of the previous questions.

**Section For Use by Therapist**

GP referral required:  no  yes

Clearance form sent:  no  yes Date:

Clearance form received:  no  yes Date:

**Client Declaration**

I declare that the information that I have given is true and correct and that, as far as I am aware, I can undertake treatment with this establishment without any adverse effects. I have been fully informed about contra-indications and am willing, therefore, to proceed. I understand that reflexology is not a substitute for medical advice and/or treatment.

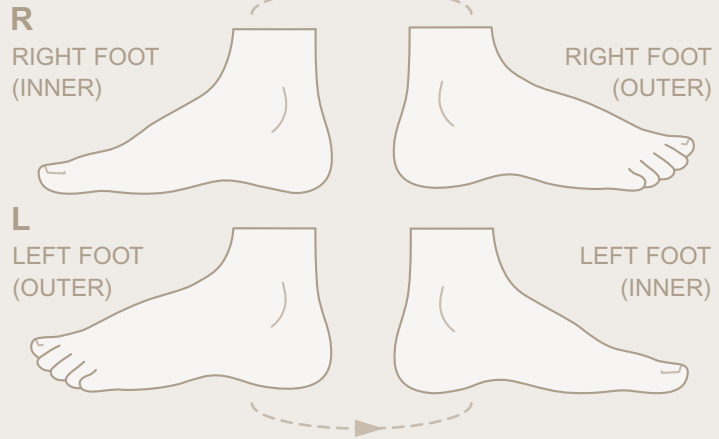
Client's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Therapist's signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Treatment Plan**



Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:
	Conclusion:		Comments:	
Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:
	Conclusion:		Comments:	
Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:
	Conclusion:		Comments:	
Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:
	Conclusion:		Comments:	
Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:
	Conclusion:		Comments:	

Aftercare Advice:

Comments: