REFLEXOLOGY CONSULTATION

Personal Information

Name: .... **D.O.B:** .... **Gender:** ....

Address: .... **Marital Status:** ....

.... **No. of Children:** ....

Tel: (Home) .... **(work):** .... **(cell):** ....

Email: .... **Occupation:** ....

Medical History

Name & Address of Doctor: ....

Serious Childhood Illnesses: ....

Surgical Operations (within 5 yrs): ....

....

Chronic Illnesses: ....

Mental Health Conditions: ....

Medication

Prescribed by a doctor: ....

Self-prescribed: ....

Medical Conditions:

Digestive System (IBS, Colitis, Constipation etc): ....

....

Endocrine System (Hormonal, Diabetes, Menopause etc): ....

....

Respiratory/Circulatory Systems (heart, BP, Lungs, Sinusitis etc): ....

....

Skeletal/Muscular Systems (Arthritis, back, neck, muscular/joint problems): ....

....

Urinary System (Cystitis, Incontinence, Kidney problems): ....

....

Allergies: ....

Headaches/Migraines: ....

Notes: ....

....

Female/Male Section

Do you have any problems with the following: Menstrual cycle, PMS, Endometriosis, Fibroids, Menopausal, Prostate, etc:

....

Are you pregnant, or trying to get pregnant?: ....

Reason for treatment: ....

....

Foot Conditions

Do you suffer from any of the following: Athletes Foot, Warts, Corns, Bunions, Fallen arches, Callouses, Plantar Fasciitis:

....

Skin/Feet Condition: ....

Lifestyle

Diet: ....

Fluid Intake: ....

Smoker/Non Smoker: .... **Energy Levels:** ....

Sleep Patterns: ....

Exercise: .... **Stress Levels:** ....

Expectations of Treatment: ....

General Notes: ....

....

....

I confirm that the above information is correct at the time of consultation

I understand that all the information will be treated with the utmost confidentiality

I am aware that 24 hours' notice must be given for all cancelled appointments or a cancellation fee will be applied

I am aware that I am solely responsible for payment at the time the services are rendered and the treatment may be covered by my insurance benefit plan with Greenshield, Blue Cross or Sunlife.

Signed: .... **Date:** ....

Referral: ....