REFLEXOLOGY With Anna Fornal

Name of Client	**M / F Surname**	**Forename**
Address **EMAIL in CAPITALS**	□ tick here if you would not like to be contacted	
Telephone No(s)	**Home**	**Mobile**
Occupation **Shifts/ Nights/ Irregular**		**Date of birth**
Doctor's **Name/Address**	**EMERGENCY CONTACT :**	

LIFESTYLE INFORMATION	**MEDICAL INFORMATION**
Height & Weight (Approx)	Circulation/**Blood Pressure** – Normal / High / Low/ Fainting/
Dependents/Children/Elderly/Sick/Disabled Yes / No / How many?	**Digestive Disorders** – constipation / bloating / diarrhoea / flatulence / indigestion
Nutritional Intake – healthy / balanced / poor / eat regularly / erratically **ANY SPECIAL DIET**?	**Muscular aches & pains** / rheumatism / arthritis / postural or spinal defects
Alcohol – How many units a week? 250ml of wine or stronger beer = 3units Smoking No / Yes / How many?	Respiratory problems: Asthma/ Do you use an inhaler?
Exercise DO YOU EXERCISE REGULARILY? Active or Sedentary lifestyle?	**Reproductive** – PMS / Menopause / Prostate / **COULD YOU BE PREGNANT?**
Glasses/Contact Lenses – Yes / No/ For Reading only	Sinus/headaches/migraines
Fluid Intake Daily – tea/coffee/water	**MEDICAL HISTORY** & Family History
Allergies (nuts, hay fever, wheat) **Anaphylaxis**	**Current Medication** & What For (including pill &HRT) or supplements
Sleep Patterns - HOW WELL DO YOU SLEEP? Restless/ Well/ Poorly/Don't feel refreshed am	**STRESS LEVEL** /Depression – on a scale of 1 - 10 **WHAT DO YOU DO TO RELAX?**

REASON FOR TREATMENT:

HAVE YOU HAD REFLEXOLOGY BEFORE?

RECEIVING OTHER THERAPIES?

CONTRA-INDICATIONS check form – please tick if any of the following are applicable, give details below

HEMOPHILIA (prolonged bleeding)		**ARTHIRITIS**	
VARICOSE VEINS/ THROMBOSIS		**Neurological condition**	
PHLEBITIS (inflamed vein due to blood clots or damage to the walls of the vein)		**PSORIASIS or ECZMA**	
DIABETES		**Medical OEDEMA/ swelling**	
CANCER		**SCABIES/ OTHER SKIN CONDITION** **RINGWORM** (fungal infection of the skin) **IMPETIGO (**bacterial skin infection **)**	
HEART CONDITION/ STROKE /ANGINA		**STRESS/ DEPRESSION/ ANXIETY**	
MULTIPLE SCLEROSIS		**SKIN SENSITIVITY or ITCHING**	
EPILEPSY		**Scalp/hair condition**	
KIDNEY PROBLEMS		**Infectious/ contagious disease**	
OSTEOPOROSIS		**ATHLETE'S FOOT**	
CRON'S DISEASE – INFLAMATORY BOWEL DISEASE OR COLITIS		**CONSTIPATION/ DIARRHOEA**	
PARKINSON'S DISEASE		**Under influence of alcohol**	
Recent operations/ scar tissue		Any other condition not mentioned above	

CONTRA-INDICATIONS -DETAILS

I confirm that the information I have given is true and correct and, as far as I am aware, I can undertake treatment with this establishment without any adverse effect. I have been fully informed about contraindications and I am therefore willing to proceed.
I understand that I am to notify my therapist of any changes in my medical profile, well-being and health care.
I understand that at least 24 hours of notice is required for cancellation of an appointment.

☐ I HAVE READ AND ACCEPT THE "NOW SHOW AND CANCELLATION POLICY"

Client's Signature Date of Consultation

Therapist's Signature Therapist's Name