Confidential Client Medical History Form.

Name: -- DOB: ----------------------------- M/F

Address: ---

-- Postcode: ---------------------------

Phone Home: ------------------ Work: ---------------- Mobile: ---

Contact telephone number in case of emergency: ---

Email: ---

Would you like to be included on our email list? Yes/No

Occupation: ---

Cultural considerations: ---

Reason for consultation: --

Current Medical conditions:

____

____

____

____

Current medication/treatment for this condition:____________________________________

____

Other current Treatments/medication (including herbs, supplements etc.)_______________

____

Are you seeing Other Health Care professionals?(please list):

____

Please tick (✔) all conditions that you have/had

- ☐ Heart, circulatory disorders
- ☐ High/Low blood pressure
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Phlebitis/DVT
- ☐ Infectious disease
- ☐ Rash, athletes foot/ tinea
- ☐ Allergies
- ☐ Diabetes
- ☐ Chronic pain
- ☐ Pregnancy
- ☐ Fertility issues
- ☐ Reproductive disorders
- ☐ Cancer/tumours
- ☐ Asthma or lung conditions
- ☐ Abdominal/digestive problems
- ☐ Arthritis
- ☐ Numbness or tingling
- ☐ Bone injuries
- ☐ Muscle or joint pain
- ☐ Vision disorders
- ☐ Hearing disorders
- ☐ Fatigue
- ☐ Depression
- ☐ Seizures
- ☐ Stroke
- ☐ Skin disorder
- ☐ Sleep disorder
- ☐ Headaches/migraines
- ☐ Hernias

Surgical Procedures: ---

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LIFESTYLE :
Exercise: type/frequency____

Hobbies / interests ____

Diet: vegetarian/ low fat/eating program/balanced /other ____________________________

Appetite: poor /normal /excessive **Weight**: under/ average/ over

Coffee *per day*: ___ Tea *per day*: _____ Soft drinks *per day:* _______ Water glasses *per day*: ______

Sweets /cakes/ chips etc _________

Cigarettes *per day* ____ Alcohol: *glasses per day/week* ___ Recreational Drugs: *per day/week* ___
Do you want make any changes to the above? Yes / No

Sleep patterns:
Sleeps well: every night/mostly/sporadically/never/

Difficulty falling asleep: Yes/ No / sometimes

Sleeping pattern changed: Yes/No If Yes when? ____________

Wake regularly at specific times/s________________

Hours sleep per night________ go to bed at _________wake up at _________

Do you become tired during the day?

How would you rate your stress levels on a scale of 1(no stress)-10(highly stressed)
home____ work______

EMOTIONS:
Please circle words that best describe how you generally feel.

Patient/mild/understanding/sympathetic/positive/happy/selfconfident/vital/motivated.
Aggressive/impatient/angry/indecisive/hysterical/selfpitying/depressed/anxious/hopelessness

Please circle how best describes how you feel **today.**

Patient/mild/understanding/sympathetic/positive/happy/selfconfident/vital/motivated.

Aggressive/impatient/angry/indecisive/hysterical/selfpitying/depressed/anxious/hopelessness

I understand that in accordance with the scope of practice of reflexologists, as well as adhering to regulatory and statutory requirements, it is not the roll of the reflexologist to diagnose injury or illness, or to prescribe medication.

Signature________________________________ Date______________