FACIAL REFLEXOLOGY

Consultation Form

Clients Name: **Address:** **Tel No:** **Email:** **D.O.B:**	**GP Name:** **Clinic Address:** **Tel No:** **Permission to contact:** YES / NO

Family Circumstances: (partner / dependants)

Occupation:

FT / PT

Medical History: (illnesses, diseases, disorders, accidents, injuries, operations etc)

GP Referral Obtained ☐

Family Medical History:

Medication: (past and present)

Side effects of medication:

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Presenting Conditions: (reasons for Facial Reflexology)

Signs and symptoms:

Possible causes:

How does stress manifest itself in you:

LIFESTYLE

Diet: (typical daily intake, fluids & supplements)

Exercise:

Smoke / Alcohol Consumption:

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Hobbies / Relaxation:
Stress Levels / Worries and Fears:

System overview	
Musculoskeletal RSI/ Tennis elbow	**Respiratory** Asthma/ Emphysema/ Bronchitis/ Sinusitis/Other
Any problems or pain with muscles or joints in your neck, shoulders, mid or lower back, legs, arms, hands or feet?	*Do you suffer from asthma, or have a tendency to breathlessness or coughs settling on your chest? Do you have a tendency to suffer from sinus, throat or ear infections? Do you get frequent coughs, colds or flu? Allergies*
Spine/ Back Pain	Allergies
Osteoporosis	Asthma
Arthritis	Breathlessness
Rheumatism	Bronchitis
Teeth	Coughs & Colds
Frozen shoulder	Emphysema
	Sinusitis
Dermatological & Cosmetic	**Cardiovascular**
Do you suffer from any infectious skin conditions like cold sores or procedures like Botox that could inhibit the effects of facial reflexology? Do you have to be careful what you use on your skin, or have any irritable skin condition like eczema or psoriasis?	*Do you have a history or abnormally high or low blood pressure? Do you suffer from palpitations or irregular heartbeat? Do you get chest pain? Do you tend to get abnormally hot or cold hands or feet? Do you suffer from frequent faintness or dizziness?*
Dermatitis/ Eczema	Palpitations
Allergies	Heart Problems
Cold Sores	Varicose Veins
Acne Boils	Blood Pressure
Psoriasis	Cramps
Face Lift	Cold Feet or Hands

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Facial Fillers	Haemorrhoids
Botox	
Lymphatic	**Gastrointestinal** IBS/ Diarrhoea/Constipation/Hernia/ Diverticulitis/
Do you have any tendency to water retention, cellulite or swollen ankles?	*Do you suffer from frequent indigestion? Do you have a tendency to constipation or diarrhoea? What is your appetite like?*
Tonsils/ Tonsillitis	Indigestion
Glands	Flatulence
	Dry Mouth
	Tongue – Colour
	Bowel Habit
	Constipation/ Diarrhoea
Nervous System	**Urogenital** Cystitis/ Other
Do you have a tendency to headaches or migraines, or suffer from numbness or tingling in fingers and toes?	*Do you have a tendency to cystitis or thrush? Do you have any difficulty with urination, or need to urinate frequently?*
Headaches	Kidneys
Insomnia (see later)	Cystitis
Drowsiness	Fluid Retention
Excessive Sweating	
Mood Swings	
Endocrine	**Gynaecological** Endometriosis/ Prostate/ Other
Do you suffer from a thyroid condition or diabetes?	*Regular cycles? Any pain with your menstrual cycle? Current cycle – where? Suffer from PMS? What symptoms do you experience? Is there any possibility that you may be pregnant? What week of pregnancy? Is this your first child? What were your previous pregnancies like? Are you experiencing any problematic symptoms with your pregnancy? Are you experiencing any problematic symptoms with your menopause?*
Thyroid Condition	Periods
Diabetes	Last Period
	Bloating
	PMT
	Endometriosis/ Cysts

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Details of previous Reflexology treatments and any reactions:

Other Complementary Treatments:

Reason why they are having them

Any Additional Information:

Aftercare Advice that you have given after the treatment:

The information used on this consultation sheet is treated with the strictest confidence and is used in the learner's portfolio for assessment evidence only. Any treatment carried out by the learner is performed with your agreement and at your own risk.

Client Signature: **Date:**