1 Client Consultation *Session number*

Name		**Date of Consultation**	
Date of Birth		**Telephone Number**	
Address			
Email			
Emergency contact name		**Emergency contact telephone**	
Age group	*Please circle* **Under 20 20-29 30-39 40-49 50-59 60+**		
Gender	*Please circle* **Male Female Non-binary A gender not listed here Prefer not to say**		
Reason for visit			
How would you rate your health?	*Please circle* **Excellent Good Fair Poor**		
Stress levels	*Please circle score from 1 - 10 with 10 being highest* ***1 2 3 4 5 6 7 8 9 10***		
Diet			
Fluid intake	*What do you drink and how much per day?*		

1 Client Consultation *continued*

Sleep pattern	
Exercise	
Ability to relax	
Any recent visits to your GP?	
Current medication	
Allergies	

1 Client Consultation *continued*

Details of any surgery	

History of any of the following or any other?	*Joint/skeletal Nervous system Digestive Circulation Cardiovascular*
	Lymphatic system Reproduction Respiratory

Contra-indications (what you currently have?)	*Fever Contagious/infectious diseases Drugs or alcohol DVT*
	First trimester of pregnancy

To be completed by Practitioner

Written consent required?	**Written consent required by GP / Specialist?** *Please circle* **Yes** **No**	**Informed of consent obtained?**	**Informed of consent obtained?** Please circle **Yes** **No**

I declare that the information that I have given is true and correct and, as far as I am aware, I can undertake treatment without any adverse effects.

I understand that Reflexology is not a substitute for medical advice and/or treatment. It is my choice to receive Reflexology treatments as a form of therapy.

I understand that at any time I feel pain or discomfort during the session, I will immediately inform the practitioner so they can adjust the pressure and or treatment.

We are compliant with General Data Protection Regulations (GDPR) and are committed to ensuring the security and protection of all personal information.

Client signature