TrulyTru Reflexology

Client Consultation Form

Place of consultation		Date	

Client

Name		Phone mobile	
Address		Phone work	
		Phone home	
		Email	
Postcode			

Emergency contact

Name		Phone	

State of Heath

Energy levels	Good ☐ Moderate ☐ Poor ☐
Sleep pattern	Good ☐ Moderate ☐ Poor ☐
Stress levels	Good ☐ Moderate ☐ Poor ☐
Anxiety levels	Good ☐ Moderate ☐ Poor ☐
Depression	Yes ☐ No ☐
Allergies	Yes ☐ No ☐

Lifestyle

Exercise	None ☐ Occasional ☐ Regular ☐
Smoking	Yes ☐ No ☐ Notes: /day
Alcohol	Yes ☐ No ☐ Notes: units
Relaxation	Good ☐ Moderate ☐ Poor ☐ Methods:

Medical history

Muscular/Skeletal problems	Back ☐ Aches/pain ☐ Stiff joints ☐ Headaches ☐
Digestive problems	Constipation ☐ Bloating ☐ Liver/gall bladder ☐ Stomach ☐
Circulation	Heart ☐ Blood pressure ☐ Fluid retention ☐ Tired legs ☐ Varicose veins ☐ Cellulite ☐ Kidney problems ☐ Cold hands & feet ☐
Gynaecological	Irregular periods ☐ P.M.T ☐ Menopause ☐ H.R.T ☐ Pill ☐ Coil ☐
Nervous system	Migraine ☐ Tension ☐ Stress ☐ Depression ☐
Respiratory	Allergies ☐ Hay fever ☐ Asthma ☐
Skin	Dermatitis ☐ Acne ☐ Eczema ☐ Psoriasis ☐ Skin cancer ☐
Skin type	Dry ☐ Oily ☐ Combination ☐ Sensitive ☐ Dehydrated ☐
Immune system	Prone to infections ☐ Colds ☐ Sore throats ☐ Chest ☐ Sinus issues ☐
Medication taken	
Herbal remedies	

Contra-indications requiring medical permission

Currently being treated by a GP or another complementary practitioner for any condition? ☐ Notes:
Taking prescribed medication? ☐
Pregnant? ☐
Recent operations? Major ☐ Minor ☐ Date: Notes:
Any dysfunction of the nervous system? (e.g. multiple sclerosis, Parkinson's disease, motor neurone disease) ☐
Any skeletal/muscular conditions? (e.g. cervical spondylitis, osteoporosis, arthritis, whiplash, slipped disc) ☐
Any conditions causing muscular spasticity? (e.g. cerebral palsy) ☐
Any cardiovascular conditions? e.g. (thrombosis, phlebitis, hypertension, hypotension, heart conditions) ☐
Any mental health / psychotic conditions? ☐
Any undiagnosed pain? Notes:

Any of the following conditions:	Asthma ☐	Diabetes ☐
Epilepsy ☐	Kidney infection ☐	Cancer ☐
Haemophilia ☐	Bell's Palsy ☐	Medical oedema ☐
Trapped/pinched nerve ☐	Inflamed nerve ☐	Rheumatoid arthritis ☐

Contra-indications that restrict treatment

Fever ☐	Localised swelling ☐
Under influence of Alcohol/drugs ☐	Hernia ☐
Cuts/bruises/abrasions ☐	Inflammation ☐
Scar tissue ☐	Diarrhoea and vomiting ☐
Skin diseases ☐	Recent heavy meal ☐
Haematoma ☐	Hypersensitive skin ☐
Contagious or infectious diseases ☐	Varicose veins ☐
Undiagnosed lumps and bumps ☐	Gastric ulcers ☐
Sunburn ☐	Recent fractures ☐
Any allergies? (require medical attention) ☐	Menstruating ☐

Diet

Regular meals?	Breakfast ☐ Lunch ☐ Dinner ☐ Dietary notes:
Vitamin/food supplements?	Yes ☐ No ☐ Notes:
Fluid intake	Tea ___ Coffee ___ Fruit juice ___ Water ___ Soft ___ Other ___ units
Food allergies	Yes ☐ No ☐ Notes:

Consent

I, the undersigned declare the information above is to the best of my knowledge true and accurate and that as far as I am aware I can undertake the treatment with TrulyTru Reflexology without any adverse effects. I understand that reflexology is not a substitute for medical advice and/or treatment. I give my consent to the therapist named below to carry out reflexology treatment on me.

Please tick to confirm you have read, understood and received a copy of the GDPR policy.
☐ I confirm

Client name:	Client signature:	Date:

Therapist Name:	Therapist signature:	Date: