



CONSULTATION FORM

Full Name: _____

Date of Birth: _____

Address: _____

Tel Number: _____

How did you hear about us? _____

Medical Questionnaire

Please circle 'YES' or 'NO' and write anything you think we should know in the space provided at the bottom of this form.

High or low blood pressure ?	YES	NO
Do you have a heart condition ?	YES	NO
Do you have a liver complaint ? (e.g. Hepatitis, reduced function.)	YES	NO
Do you suffer from Epilepsy ?	YES	NO

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Do you suffer from digestive problems ? (e.g. IBS, constipation.)	YES	NO	
Are your bowels regular and/or do you suffer from piles ?	YES	NO	
Do you suffer cramps after eating ?	YES	NO	
Do you have issues with your bladder/kidneys/urination ?	YES	NO	
Do you suffer with excessive perspiration ?	YES	NO	
Do you have thrombosis or an embolism ?	YES	NO	
Do you have any sensory problems ? (Blurred vision, hearing, etc.)	YES	NO	
Do you suffer from headaches ? (Associated with IBS, stress, etc.)	YES	NO	
Do you have any respiration or sinus issues ? (Allergies, asthma, etc.)	YES	NO	
Do you have diabetes ? (Tell us how its managed/about complications)	YES	NO	
Do you have regular periods ?	YES	NO	N/A
Are you currently pregnant ?	YES	NO	N/A
Are you trying to become pregnant ?	YES	NO	N/A
Do you have any skin disorders ? (Eczema, psoriasis, etc.)	YES	NO	
Do you have any allergies ?	YES	NO	
Have you had any serious accidents or injuries ?	YES	NO	
Have you had any operations ?	YES	NO	
Do you have any discomfort/pain in your body ?	YES	NO	
Do you suffer from anxiety/depression ?	YES	NO	

If you answered yes to any of the above, please provide details below:

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Medication, Family History & Your Doctor

Please tell us about any regular medications:

Please tell us about any relevant family medical history? (e.g. heart disease, circulatory problems)

Name of your doctor/GP:

Surgery Address:

GP/Surgery Telephone:

Is GP referral required: YES NO

If yes, please sign the following declaration:

A doctor has been consulted and has no objection to reflexology treatment being carried out.

Sign: _____ Print Name: _____

Date: _____

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Lifestyle & Personal Details

Do you have a spouse/partner ?	YES	NO
Do you have children ?	YES	NO
What is your occupation ?		
How do you feel about your occupation ?		
Do you smoke ? (If yes, please tell us how many per day)	YES	NO
Do you drink alcohol ? (If yes, please tell us how often/units per week)	YES	NO
Do you use recreational drugs ?	YES	NO
Do you eat a well-balanced diet ?	YES	NO
Do you get 7-8 hours' sleep each night ?	YES	YES
How often do you exercise ?		
What are your hobbies ?		
Are you going through major life changes ? (e.g. menopause, job loss) (If yes, please tell us more)	YES	NO
Please rate your stress level at home : 1 2 3 4 5 6 7 8 9 10 (If 8 or more, please tell us why)		
Please rate your stress level at work : 1 2 3 4 5 6 7 8 9 10 (If 8 or more, please tell us why)		
Would you say your energy level is: (If poor, please tell us why)	HIGH	AVERAGE POOR
Have you had any previous holistic therapy treatments? (If yes, please tell us more)	YES	NO

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Client Declaration

The information I have given regarding my medical details is accurate.

I have not knowingly omitted anything that may affect my health or the treatment.

I will promptly notify Dragon Relaxology of any future changes to my health.

Sign: _____

Print Name: _____

Date: _____