skin allergies)	
Cancer: (diagnosis, date, treatment, medication, prognosis, remission, family history)	□ Yes □ No
Allergic reactions: (triggers e.g. medication, food, additives)	□ Yes □ No
Diabetes: (stable, unstable, diet or medically controlled, family history)	□ Yes □ No
Operations: (dates, locations, scarring)	□ Yes □ No
Sleep: (pattern, duration, ease of getting to sleep, wake feeling refreshed, disturbed)	
Exercise: (type & frequency)	
Hobbies / pastimes:	
Medications: prescribed, supplements, over the counter)	
Diet: (normal, reduction, gluten free, diabetic)	
Daily fluid intake:	□ Water □ Tea □ Coffee □ Fruit Juice □ Other
Smoking:	□ No □ Yes – How many per day?

Stress Levels

How would you rate your stress levels on a scale from 1 – 10 (10 being the highest)?	1	2	3	4	5	6	7	8	9	10

Additional Information

Declaration

I hereby declare that I have answered the consultation fully and I have not withheld any information that may affect the outcome of the treatment. Treatment has been fully explained and I have been made aware of any possible reactions which could occur.

I know of no reason why I cannot undertake reflexology treatment. It is my responsibility to notify the therapist of any medical changes that may effect any treatment either now or in the future.

Client Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____