Personal Details (Confidential)

Name:	
Address:	**Postcode:**
Telephone Number	
Email Address:	
GP Name and Address	

Practitioner :

I understand that although my case may be discussed with other relevant professionals, none of my personal information will be shared and I will be identified by a client code.

I accept that the information provided is a true and accurate reflection of my state of health and I undertake to inform the practitioner of any changes in my health whilst receiving the course of treatment. I give permission for Reflexology to be carried out and for my practitioner to contact my GP, with my knowledge, if it is appropriate. I have had the treatment explained to me and accept full responsibility.

Client's signature _____ **Date** _____

Client Code
Date of Birth:
Height:
Weight:
Marital Status:
Support Network:
Occupation:
Lifestyle:
Smoking Habits:
Alcohol Consumption:
Diet:
Fluid Intake:
Nutritional Supplements:
Exercise:
Sleep Pattern
Current Stress Levels and Reasons:

Medical History:

General Health:
Surgery (incl. Dates):
Injuries, Illnesses and Accidents (incl. Dates):
Allergies:
Diagnoses:
Current Medication:
Past Complementary Treatments & Benefits

First Reflexology Treatment:

Date:
Presenting Condition/Reason For Having Reflexology:
Date Diagnosed:
Who Diagnosed:
Problems:
Practitioner's Plan:

Practitioner's Signature **Date**

Print Name