|  |  |
| --- | --- |
| **Clients Name:****Address:****Tel No:****Email:****D.O.B:** | **GP Name:****Clinic Address:****Tel No:****Permission to contact: YES / NO** |

|  |
| --- |
| **Family Circumstances:** (partner/dependants) |
|  |
| **Occupation:** **FT / PT** |
|  |
| **Medical History:** (illnesses, diseases, disorders, accidents, injuries, operations) **GP Referral Obtained ⬜** |
|  |
| **Family Medical History:**  |
|  |
| **Medication:** (past and present)**Side effects of medication:** |

|  |
| --- |
| **The information used on this consultation sheet is treated with the strictest confidence. Any treatment carried out is performed with your agreement and at your own risk. Are you happy to receive offers and information from Hitchin Reflexology Yes/No****Client Signature: Date:** |

|  |
| --- |
| **System overview** |
| Musculoskeletal RSI/ Tennis elbow | **Respiratory Asthma/ Emphysema/ Bronchitis/ Sinusitis/Other** |
| ***Any problems or pain with muscles or joints in your neck, shoulders, mid or lower back, legs, arms, hands or feet?*** | ***Do you suffer from asthma, or have a tendency to breathlessness or coughs settling on your chest? Do you have a tendency to suffer from sinus, throat or ear infections? Do you get frequent coughs, colds or flu? Allergies*** |
| **Spine/ Back Pain** | **Allergies** |
| **Osteoporosis** | **Asthma** |
| **Arthritis** | **Breathlessness**  |
| **Rheumatism** | **Bronchitis** |
| **Teeth** | **Coughs & Colds** |
| **Frozen shoulder** | **Emphysema** |
|  | **Sinusitis** |
|  |  |
| Dermatological  | Cardiovascular |
| ***Do you suffer from any infectious skin conditions like verrucae or athletes foot? Do you have to be careful what you use on your skin, or have any irritable skin condition like eczema or psoriasis?*** | ***Do you have a history or abnormally high or low blood pressure? Do you suffer from palpitations or irregular heartbeat? Do you get chest pain? Do you tend to get abnormally hot or cold hands or feet? Do you suffer from frequent faintness or dizziness?*** |
| **Dermatitis/ Eczema** | **Palpitations** |
| **Allergies** | **Heart Problems** |
| **Verrucae** | **Varicose Veins** |
| **Athletes Foot** | **Blood Pressure** |
| **Acne Boils**  | **Cramps** |
| **Psoriasis** | **Cold Feet or Hands** |
|  | **Haemorrhoids** |
|  |  |
| Lymphatic | **Gastrointestinal IBS/ Diarrhoea/Constipation/Hernia/ Diverticulitis/**  |
| ***Do you have any tendency to water retention, cellulite or swollen ankles?*** | ***Do you suffer from frequent indigestion? Do you have a tendency to constipation or diarrhoea? What is your appetite like?*** |
| **Tonsils/ Tonsillitis** | **Indigestion** |
| **Glands** | **Flatulence** |
|  | **Dry Mouth** |
|  | **Tongue – Colour** |
|  | **Bowel Habit** |
|  | **Constipation/ Diarrhoea** |
|  |  |
| Nervous System | Urogenital Cystitis/ Other |
| ***Do you have a tendency to headaches or migraines, or suffer from numbness or tingling in fingers and toes?*** | ***Do you have a tendency to cystitis or thrush? Do you have any difficulty with urination, or need to urinate frequently?*** |
| **Headaches** | **Kidneys** |
| **Insomnia (see later)** | **Cystitis** |
| **Drowsiness** | **Fluid Retention** |
| **Excessive Sweating** |  |
| **Mood Swings** |  |
|  |  |
| Endocrine | **Gynaecological Endometriosis/ Prostate/ Other** |
| **Do you suffer from a thyroid condition or diabetes?** | ***Regular cycles? Any pain with your menstrual cycle? Current cycle – where? Suffer from PMS? What symptoms do you experience?*** ***Is there any possibility that you may be pregnant? What week of pregnancy? Is this your first child? What were your previous pregnancies like? Are you experiencing any problematic symptoms with your pregnancy?*** ***Are you experiencing any problematic symptoms with your menopause?*** |
| **Thyroid Condition** | **Periods** |
| **Diabetes** | **Last Period** |
|  | **Bloating** |
|  | **PMT** |
|  | **Endometriosis/ Cysts** |
|  |  |