

Describe a typical nights sleep (If disturbed)

Do you feel tired or refreshed when you wake?

Presenting condition for which treatment is sought(Diagnosis, when symptoms occur, duration of symptoms, exacerbations, relievers)

Date,origin of onset (emotions at time)

Personality: How would you describe yourself?

Any known foot conditions? (Athletes foot, verrucas, bunions)

How do you feel about your feet?

**CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION - in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment**

(Either of which needs to be attached to the consultation form.)

Written Permission required by (GP/Specialist or Informed consent) : \_\_\_\_\_

- I, the undersigned, confirm that the above information is accurate and true to the best of my knowledge.
- I understand that all the information will be treated with the utmost confidentiality.
- I declare that to the best of my knowledge I am not allergic to any of the ingredients in the treatment cream.
- I give my consent for the student therapist named below to carry out reflexology treatments upon me.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapists Signature : \_\_\_\_\_ Date: \_\_\_\_\_