SOLE TO SOUL THERAPY

We kindly ask you to complete the form below to the best of your ability.

If you have any questions regarding the form, please contact me

PERSONAL DETAILS			
Full name:		Phone number(s)	
Age:		Next of kin:	
Occupation:		Number of children (if relevant)	
Email:			
Address			

HEALTH INFORMATION			
Name of GP:		Alcohol (units per week)	
Date of birth:		Smoke (how many and for how long)	
Medications currently taking (what / how often/ for how long)			
Surgery name and address			

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Please tick any of the conditions below you have or had							
Asthma		Depression		Emphysema		Headaches / Migraines	
Arthritis		Cancer		Fibromyalgia		Digestive problems	
Allergies		Epilepsy		Gout		Inflammation	
Bronchitis		Bipolar disorder		Heart problems		Muscular problems	
Breathing problems		Diabetes		High / Low blood pressure		Osteoporosis	
Stress / Anxiety		Structural (bones) problems		Thrombosis		Varicose veins / Phlebitis (in treatment area)	
For any conditions you have ticked, please describe briefly how the condition affects you and how long you have had it?							
Any other medical condition you think would be useful to know about?							
Family medical history if relevant?							

RECENT MEDICAL HEALTH	Yes	No
Are you currently receiving treatment from a medical practitioner?		
Are you scheduled for any medical tests or procedures in the next 2 weeks?		
Do you have any areas of pain at the moment?		
Recent surgery? (if so when)		
Frequency of pain?		
Date of last period / how are your periods? (if applicable)		

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LIFESTYLE					
What do you drink in a day e.g water, tea, coffee (caffeinated or decaffeinated)?					
Do you exercise regularly? 1=Never to 5 =Often (please tick)	1	2	3	4	5
How is your diet? 1=Unhealthy to 5 =Very Healthy (please tick)	1	2	3	4	5
How would you rate your energy levels? 1=Very Low to 5 =Very High (please tick)	1	2	3	4	5
How would you rate your sleep 1=Bad to 5 =Good (please tick)	1	2	3	4	5
How would you rate your stress levels 1=Bad to 5 =Good (please tick)	1	2	3	4	5

Have you had a holistic treatment before, if so, describe the treatment:	

What would you like to achieve from your treatment e.g Relaxation or Specific areas of concern?	

Any other information that you feel would be relevant?

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CONFIDENTIALITY
I confirm I will not share your details with anyone else. The information I am obtaining is solely needed to enable me to give you the best possible treatment.

I am pregnant or trying to become pregnant. I have discussed this with my reflexologist and I understand that while there is a natural chance of miscarriage throughout pregnancy but especially in the first trimester, there is no evidence that reflexology causes miscarriage. I am happy to go ahead with the treatment.

Date: Sign.....

CLIENT DECLARATION
I understand that Sonia does not diagnose illness, disease, any physical or mental disorder, nor does she prescribe medical treatment, medication or perform Joint mobilisation.
I acknowledge that holistic therapies are not a substitute for a medical examination or diagnosis & a doctor should be seen for that service.
It is my choice to receive reflexology treatments as a form of therapy. I also understand that at any time I feel pain or discomfort during the session, I will immediately inform Sonia so she can adjust the pressure & or treatment.
I have stated my current medical conditions & medication, I will update Sonia of any change in my health status.

Date: Sign.....

(If applicable) Print name:
Parental signature if client is under 16 years old

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