

Consultation Form



Title _____ First Name _____ Family Name _____ D.O.B. _____ Female Male
Email _____ Telephone _____
Address _____
How did you hear about Aeon Reflexology? _____
Doctors Name _____ Surgery Telephone _____
Surgery Address _____

Medical information

If you have any health condition (whether or not listed below) we recommend that you proceed only with your doctor's approval.

Heart conditions/Strokes	Kidney/Liver disorders	Joint problems	Multiple sclerosis	Product allergies
Cancer/Chemotherapy	Thyroid problems	Osteoporosis	IBS	Skin sensitivity/Allergies
Secondary Lymphoedema	Poor circulation	Osteoarthritis	Crohns disease	Hormonal imbalance
High/Low blood pressure	Recent operations	Rheumatoid arthritis	Muscular pain	Psoriasis/Eczema
Diabetes (Type 1 or 2)	IVF/Breast feeding	Chronic fatigue	Asthma	Foot infections
Epilepsy	Depression/Anxiety	Fibromyalgia	Varicose veins/DVT	
Hepatitis	Water retention/Oedema	Lupus	Thrombosis	

If you have ticked any of the above health conditions, please provide more information here:

Are you taking any medication or homeopathic supplements?

Specific hormonal concerns

Do you suffer from any of the following:

Irregular periods	Mood swings	Sleep disturbances	Backache	Morning sickness or nausea
Heavy periods	Irritability	Memory fog	Neck ache	Heartburn
No menstruation	Stress	Digestive issues	Other skeletal pain	Hot flushes
Ovulation pain	Bloating	Constant fatigue	Haemorrhoids	Night sweats
Headaches/migraines	Breast tenderness	Acne	Constipation	

Date of last menstruation _____ Next period due date _____ Normal length of menstruation _____

Could you be pregnant? _____ If yes, how many weeks pregnant are you? _____

What is your due date? _____ Are there any complications with your pregnancy? Yes no

If yes, please explain _____

Have you been through the menopause in the last 2 years? Yes no

If yes, when was your last menstruation? _____

Are you in pain? yes no

If yes, please explain _____

Would you say your general health is poor average good

Is there anything else you think we should know regarding your health that may affect or prevent you having treatment? _____

(for reflexologists use only)

Notes:

first visit

What are your main concerns?

What results would you like to achieve?

Your Permission

I consent to the use of my personal data (including any sensitive personal data) for the purpose of my treatment and any future treatment. I agree that any treatment is at my own risk without limiting or affecting my statutory rights. Aeon Reflexology complies with the data protection act 1998 and the requirement for handling personal data and sensitive personal data.

Client signature (1st visit) _____ Date _____

Please tick here if you do not wish to receive future promotional or event mailings:

for reflexologists use only

Date: _____ Reflexologist: _____ Treatment: _____

Treatment notes and plan: