



**REFLEXOLOGY**  
**CONSULTATION CARD**

Client's Name : (Mr,Mrs,Miss,Ms) \_\_\_\_\_

Address: \_\_\_\_\_

Tel:(home)\_\_\_\_\_ (mobile)\_\_\_\_\_ (work)\_\_\_\_\_

Date of Birth:\_\_\_\_\_ Occupation \_\_\_\_\_

I have agreed to be a case study for .....a student  
Practitioner in .....

- I have undertaken a full consultation and completed the lifestyle questionnaire prior to treatment, which is complete and to the best of my knowledge.  
ข้าพเจ้าได้รับการวิเคราะห์อย่างเต็มรูปแบบและตอบคำถามเกี่ยวกับการใช้ชีวิตประจำวันก่อนหน้าที่จะเข้ามา  
รับการบริการทรีทमेंท์ ซึ่งเป็นข้อมูลที่ถูกต้องที่สุด
- I have obtained medical consent from my G.P. to have this treatment.  
ข้าพเจ้าได้รับการยินยอมจากนายแพทย์เพื่อที่จะรับการบริการนี้
- I have not obtained medical consent from my G.P. to have this treatment.  
ข้าพเจ้าไม่ได้รับการยินยอมจากนายแพทย์เพื่อที่จะรับการบริการนี้
- I agreed to notify the Practitioner of any change in my medical condition.  
ข้าพเจ้าตกลงที่จะแจ้งให้ผู้ให้บริการทราบในการเปลี่ยนแปลงประวัติทางการแพทย์ของข้าพเจ้า
- I have had the therapist explained to me.  
ข้าพเจ้าได้รับการชี้แจงจากผู้ให้บริการเป็นที่เรียบร้อยแล้ว

I hereby confirm that all the content in these documents are true and correct.

ข้าพเจ้าขอรับรองว่าข้อมูลทั้งหมดถูกต้องและเป็นความจริง

Client's Signature.....Date.....

Client Overview: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been referred for treatment?

**Medical History**

*Doctors permission required*

*Yes No*

Do you take medication and what for? \_\_\_\_\_

Do you have any of the following?

*Please circle Additional information*

- |                                    |        |
|------------------------------------|--------|
| ❖ Fever/raised body temperature    | NO YES |
| ❖ Limitation of body movement      | NO YES |
| ❖ Swelling/oedema                  | NO YES |
| ❖ Haemophilia                      | NO YES |
| ❖ Cancer                           | NO YES |
| ❖ Hormone imbalance                | NO YES |
| ❖ Deep vein thrombosis/embolism    | NO YES |
| ❖ Diabetes                         | NO YES |
| ❖ Epilepsy                         | NO YES |
| ❖ HIV or AIDS                      | NO YES |
| ❖ Hepatitis B                      | NO YES |
| ❖ Metal pins and plates            | NO YES |
| ❖ Pacemaker                        | NO YES |
| ❖ Body Piercing                    | NO YES |
| ❖ Skin diseases/disorders          | NO YES |
| ❖ Scar tissue                      | NO YES |
| ❖ Heart condition                  | NO YES |
| ❖ Blood pressure                   | NO YES |
| ❖ Respiratory disorders            | NO YES |
| ❖ Cuts, bruises and abrasions      | NO YES |
| ❖ Allergies                        | NO YES |
| ❖ Any recent surgery               | NO YES |
| ❖ Papules, Pustules                | NO YES |
| ❖ Dilated capillaries              | NO YES |
| ❖ Any other (please specify) _____ |        |

### **Lifestyle Check**

Do you smoke?      **YES**      **NO**      If yes, how many a day? \_\_\_\_\_

What is your fluid intake per day? \_\_\_\_\_

Do you drink alcohol?      **YES**      **NO**      if yes how many units a day? \_\_\_\_\_

Do you sleep well/restless/poorly? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_

What types of exercise do you undertake? \_\_\_\_\_

Do you work shifts/nights/irregular hours? \_\_\_\_\_

Do you suffer with tension or fatigue? \_\_\_\_\_

Do you suffer with depression/nervous/anxious? \_\_\_\_\_

Are you receiving any other therapies or treatment at the moment? \_\_\_\_\_

Do you have a specialized diet? \_\_\_\_\_

How would you describe your diet healthy/balanced/poor? \_\_\_\_\_

Do you eat regularly/erratically? \_\_\_\_\_

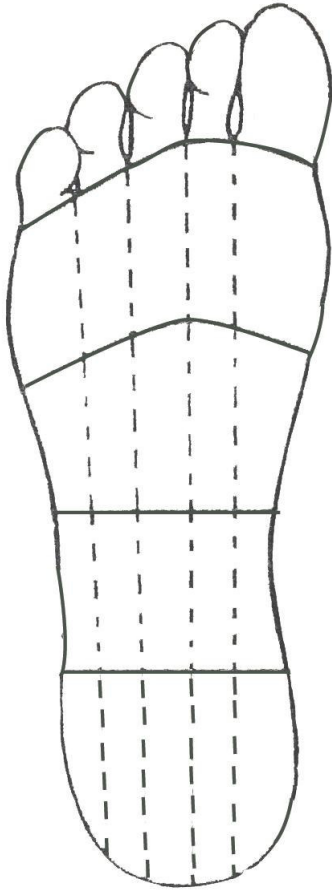
Do you suffer with migraine? \_\_\_\_\_

**Foot Analysis**

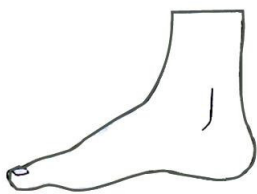
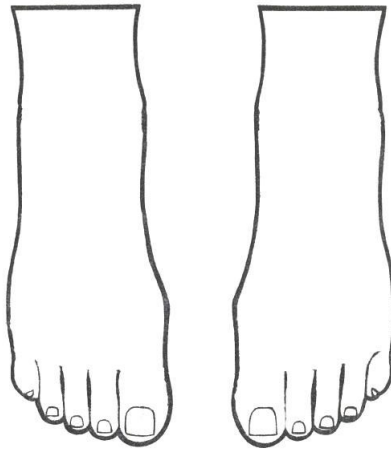
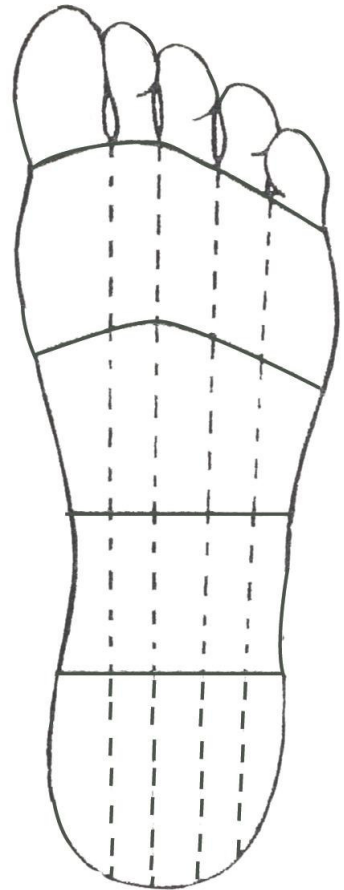
	<b>Right Foot</b>	<b>Left Foot</b>
<b>Color</b>		
<b>Texture</b>		
<b>Muscle Tone</b>		
<b>High Arch /Flat foot</b>		
<b>Skin Condition/Infection</b>		
<b>Hard Skin</b>		
<b>Skeletal Deformities</b>		
<b>Toe Nails</b>		
<b>Any Other</b>		

# Reflexology

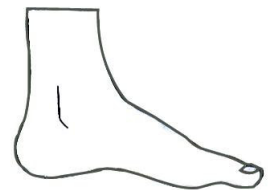
Right



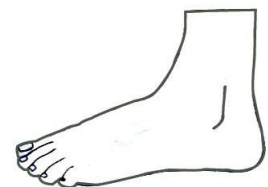
Left



Medial



Lateral



**REFLEXOLOGY RECORD CARD**

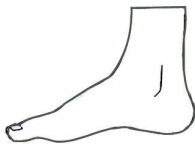
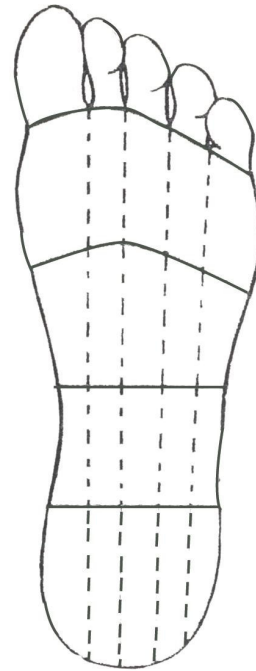
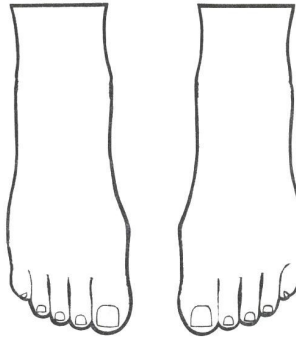
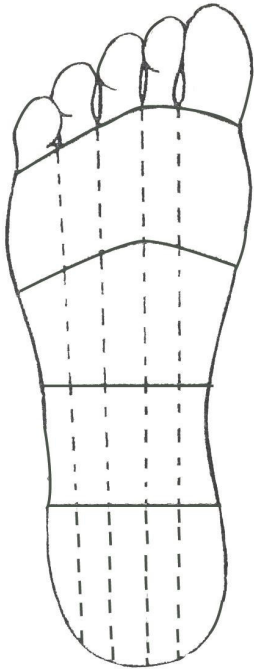
<b>Date</b>	<b>Treatment detail and condition</b>	<b>Progress</b>

Session No: \_\_\_\_\_

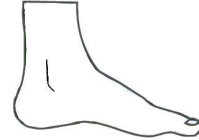
Date: \_\_\_\_\_

Right

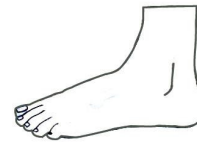
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Medial



Lateral



**AFTERCARE**

**FUTURE TREATMENT**

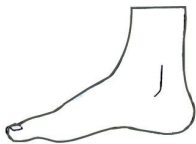
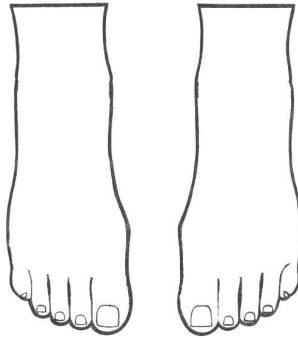
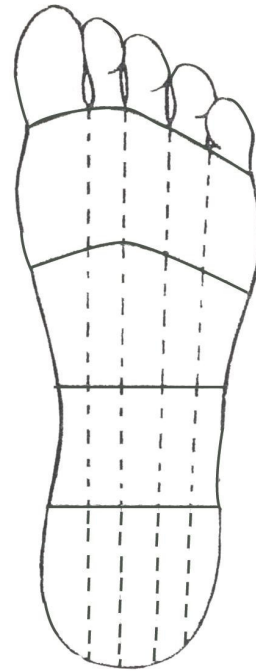
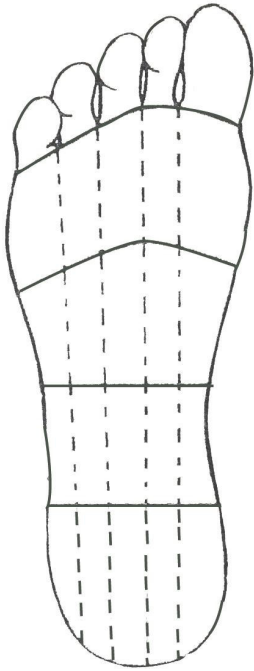
**PRODOUCT RECOMMENDATION**

Session No: \_\_\_\_\_

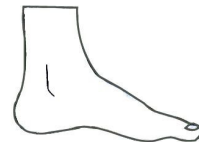
Date: \_\_\_\_\_

Right

Left



Medial



Lateral



**AFTERCARE**

**FUTURE TREATMENT**

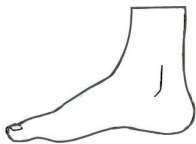
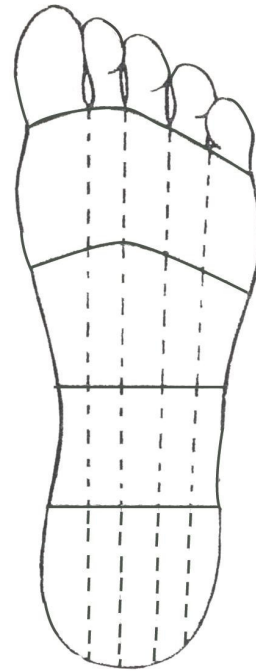
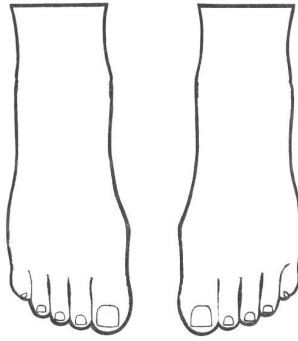
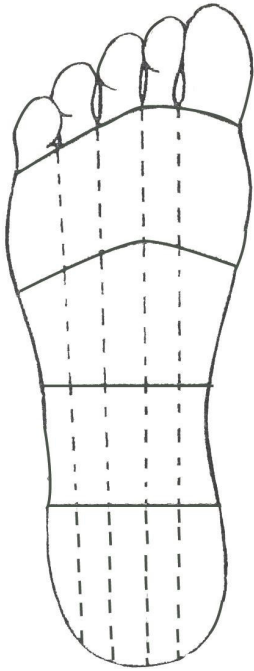
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Session No: \_\_\_\_\_

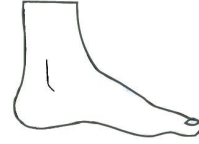
Date: \_\_\_\_\_

Right

Left



Medial



Lateral



**AFTERCARE**

**FUTURE TREATMENT**

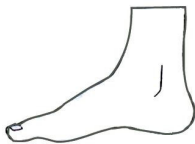
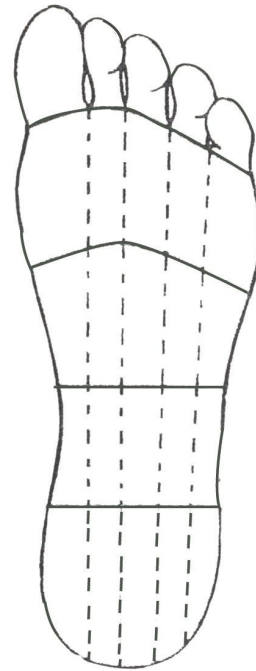
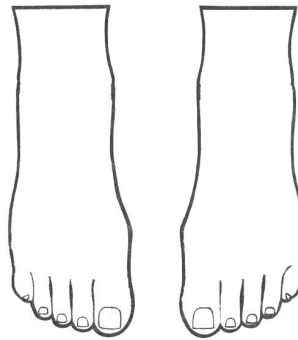
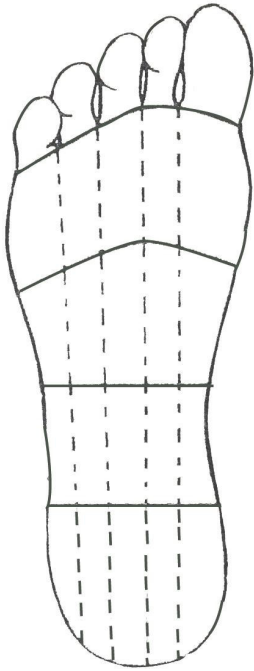
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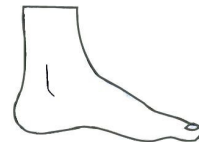
Date: \_\_\_\_\_

Right

Left



Medial



Lateral



**AFTERCARE**

**FUTURE TREATMENT**

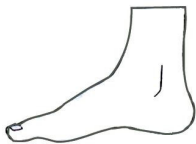
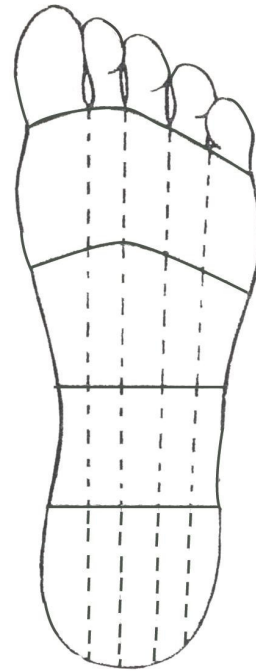
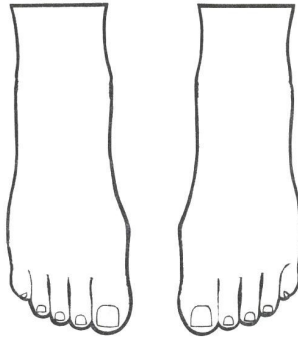
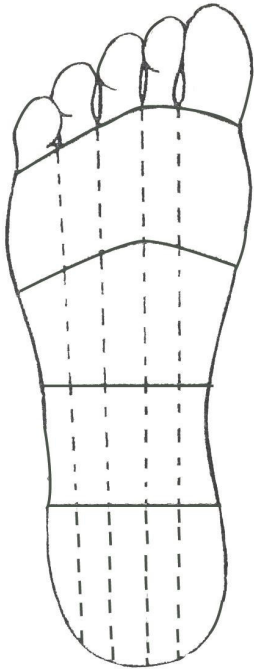
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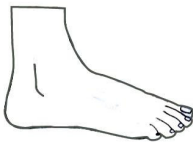
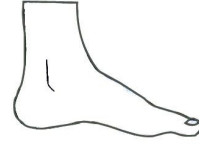
Date: \_\_\_\_\_

Right

Left



Medial



Lateral



**AFTERCARE**

**FUTURE TREATMENT**

**PRODOUCT RECOMMENDATION**

## **CONCLUSION**