Follow up Consultation Record Reflexology

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Patient's Name: _____ Follow-up Consultation Date: _____

Reflexologist Name: _____

Development in symptom picture/healing crisis: Ask the patient if there have been any improvements. Record details

Bowel situation changes Details

Menstrual situation changes (if applicable) Details

Changes in medication (under Doctor supervision): Details/dose

Vaccinations taken: Date and type

Changes in contraception: Record details

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Medical interventions/tests since last consultation: Details

Changes in medication (under Doctor supervision): Details/dose

Natural therapeutics implemented: NOTE: Ask only about natural therapeutics that were recommended at the last consultation (Hydrotherapy, liver flush, castor oil packing, other)

Lifestyle changes implemented: NOTE: Ask only about lifestyle changes that were recommended at the last consultation (Exercise, yoga, meditation, tai chi/chi kung, creativity, rest, other)

Changes in sleeping pattern: Record details

Changes in general energy levels and stress levels: Details

Follow up Consultation Record Diet Habits

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Breakfast: Details

Mid-morning: Details

Lunch: Details

Mid-afternoon Snack: Details

Evening Meal: Details

Other Snacks: Details

Meat: times per week

Chicken: times per week

Fish: times per week

Cheese: times per week

Butter: none/little/lots (state which)

Eggs: number per week

Milk: pints per week

Yogurt: times per week

Sugar: none/little/lots **Honey:** none/little/lots

Biscuits/cakes/chocolate: amount per week

Energy drinks: amount per week

Bread: white/brown (underline) amount per week

Rice: white/brown (underline) times per week

Pasta/Noodles: white/brown (underline) times per week

Salt: which type? none/little/lots (underline)

Black tea: times per day (milk yes/no) (sugar spoons)

Coffee: times per day (milk yes/no) (sugar spoons)

Cigarettes: amount per week smoker in past?

Alcohol: which type? amount per week

Recreational Drugs: which type? frequency

past use?

Water: litres per day filtered (yes/no)

Herbal teas: cups per week

Fruit: pieces per day

Juices: type

amount per day

Smoothies: type

amount per day

Sprouts: kind

amount per week

Salads: kind

times per week

Raw Garlic: times per week

Green powders healthfood shop: amt per week

Cayenne: amt per week

Other organic food supplements: kind

amount taken

Other Notes: use this space to record any other important dietary information given by the patient

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Please write a detailed description of your findings on the feet stating areas that were tender and draw them on the diagram: