First Consultation Record Reflexology

Core College

Patient's Name: _____ First Consultation Date: _____

Year of birth: _____

Reflexologist Name: _____

Main complaint and symptom picture: 3-4 main points. Use patient's words

Bowel situation: Frequency and ease. Student should explain briefly why this question is important for natural healing

Menstrual or menopausal situation: Regularity, symptoms, post or pre-menopausal?

Contraception: Pill, IUD (which type?), Patch, Bar. Number of years in use

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Medical history: Main past health issues, plus time (year is ok)

Surgery: List all surgeries, plus time (year is ok)

Injuries: List all injuries, plus time (year is ok)

Past Medications (including vits & minerals): Plus exact dose

Current Medications (including vits & minerals): Plus exact dose

Adult Vaccinations: Type and when?

Mother & mother's family med-his: Ailments, or early deaths

Father and father's family med-his: Ailments, or early deaths

Siblings medical history: Ailments, or early deaths

Patient's sleeping pattern: Record time of waking if insomniac

Exercise taken if any: Describe exercise and frequency

Any stress management techniques used: Do not ask 1-10!!!

First Consultation Record Diet Habits

Core College

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: