Consultation Form

iUCT32 – Provide reflexology for complementary therapies

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

Personal details:						
Age group:	Under 20 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Lifestyle:	Active ☐			Sedentary ☐		
Last visit to the doctor:						
GP Address:						
Number of children: *(If applicable)*						
Date of last period: *(If applicable)*						

Contra-indications requiring medical permission – *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):*					
Pregnancy	☐	Epilepsy	☐	Cancer	☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension and heart conditions)	☐	Recent operations	☐	Conditions causing muscular spasticity (e.g. cerebral palsy)	☐
Haemophilia	☐	Diabetes	☐	Kidney infections	☐
Any condition already being treated by a GP or another complementary practitioner	☐	Asthma	☐	Whiplash	☐
Medical oedema	☐	Any dysfunction of the nervous system (e.g. multiple sclerosis, Parkinson's disease, motor neurone disease)	☐	Slipped disc	☐
Osteoporosis	☐	Bell's palsy	☐	When taking prescribed medication	☐
Arthritis	☐	Trapped/pinched nerve (e.g. sciatica)	☐	Acute rheumatism	☐
Nervous/psychotic conditions	☐	Inflamed nerve	☐	Undiagnosed pain	☐

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Inflammation	☐	Hormonal implants	☐
Contagious or infectious diseases	☐	Varicose veins	☐	Haematoma	☐
Under the influence of recreational drugs or alcohol	☐	Pregnancy (first trimester)	☐	Recent fractures (minimum 3 months)	☐
Diarrhoea and/or vomiting	☐	Bruises	☐	Conditions/disorders of feet/hands	☐
Skin diseases	☐	Abrasions	☐	Menstruation	☐
Undiagnosed lumps and bumps	☐	Scar tissue (2 years for major operation and 6 months for small scar)	☐	Disorders/conditions of hands/feet/nails	☐
Sunburn	☐	Localised swelling	☐	Cuts	☐

Written permission required by – *Either of which should be attached to the treatment form (Select if/where appropriate):*			
GP/specialist	☐	Informed consent	☐

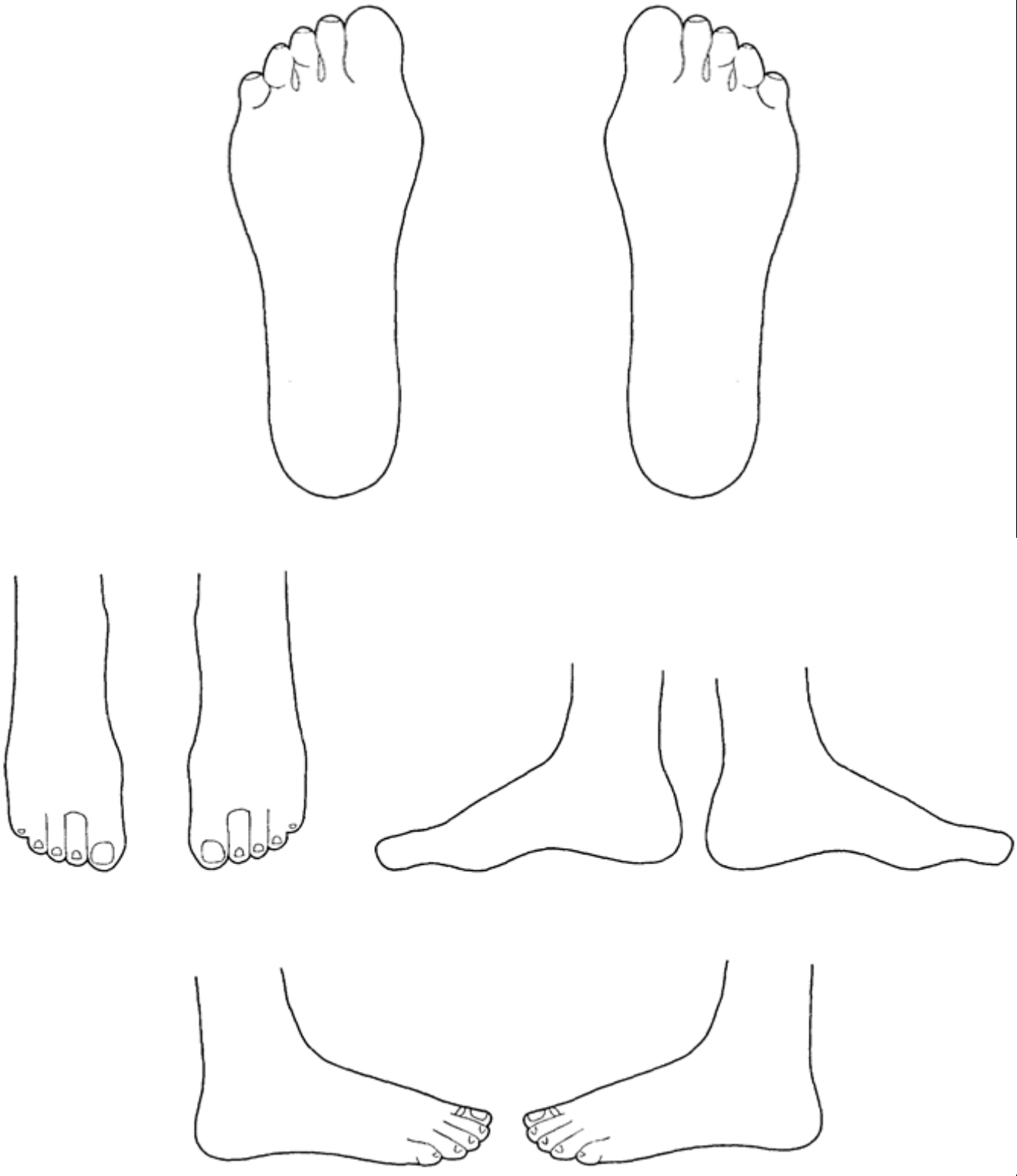
Personal information – *(Select if/where appropriate):*

Muscular/skeletal problems:	Back ☐	Aches/pain ☐	Stiff joints ☐	Headaches ☐
Digestive problems:	Constipation ☐	Bloating ☐	Liver/gall bladder ☐	Stomach ☐
Circulation:	Heart ☐	Blood Pressure ☐	Fluid retention ☐	Tired legs ☐
	Varicose veins ☐	Cellulite ☐	Kidney problems ☐	Cold hands and feet ☐
Gynaecological:	Irregular periods ☐	P.M.T ☐	Menopause ☐	H.R.T ☐
	Pill ☐	Coil ☐	Other:	
Nervous system:	Migraine ☐	Tension ☐	Stress ☐	Depression ☐
Immune system:	Prone to infections ☐	Sore throats ☐	Colds ☐	
	Chest ☐	Sinuses ☐		
Regular antibiotic / medication taken?	Yes ☐	No ☐	If yes, which ones?	
Herbal remedies taken?	Yes ☐	No ☐	If yes, which ones?	
Ability to relax:	Good ☐	Moderate ☐	Poor ☐	
Sleep patterns:	Good ☐	Poor ☐	Average No. of hours	
Do you see natural daylight in your workplace?	Yes ☐	No ☐		
Do you work at a computer?	Yes ☐	No ☐	If yes, how many hours?	
Do you eat regular meals?	Yes ☐	No ☐		
Do you eat in a hurry?	Yes ☐	No ☐		
Do you take any food/vitamin supplements?	Yes ☐	No ☐	If yes, which ones?	
How many portions of each of these does your diet contain per day?	Fresh Fruit:	Fresh Vegetables:	Protein and source:	
	Dairy produce:	Sweet things:	Added salt:	Added sugar:
How many of these drinks do you consume per day?	Tea:	Coffee:	Fruit juice:	Water:
	Soft drinks:	Others:		

Do you suffer from food allergies?	Yes ☐		No ☐	
Do you suffer from eating disorders?	Yes ☐		No ☐	
Bingeing?	Yes ☐		No ☐	
Overeating?	Yes ☐		No ☐	
Undereating?	Yes ☐		No ☐	
Do you smoke?	Yes ☐	No ☐	How many per day?	
	Other:			
Do you drink alcohol?	Yes ☐	No ☐	How many units per day?	
Do you exercise?	None ☐	Occasional ☐	Irregular ☐	Regular ☐
	Types:			
What is your skin type?	Dry ☐	Oily ☐	Combination ☐	
	Mature ☐		Young ☐	
Do you suffer/have suffered from:	Dermatitis ☐	Acne ☐	Eczema ☐	Psoriasis ☐
	Allergies ☐	Hay fever ☐	Asthma ☐	Skin cancer ☐
Stress level: 1- 10 (10 being the highest)	At work:		At home:	

Reading of the feet – *(Select if/where appropriate):*	
Contra-indications that restrict:	
Skin texture/areas of hard skin:	
Colour:	
Flexibility:	
Temperature:	
Swelling /puffiness:	
Odour:	
Foot position:	
Nail condition:	
Skeletal structure/arches of the feet:	

iUCT32 – Provide reflexology for complementary therapies – *Treatment No:*



Client name:	
Treatment date:	

Client profile– *(To include lifestyle):*

Treatment plan:

Client feedback:

Home care advice given including recommendations for self-treatment:

Self-reflection and evaluation of the treatment *(this field to be completed for case studies only):*

Any CPD requirements: – *(this field to be completed for case studies only on conclusion of treatment programme):*

Therapist/learner signature: _____

Client signature: _____

Continuation sheet – Treatment No:

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Client name:	
Treatment date:	

Reading of the feet:	
Contra-indications that restrict:	
Skin texture/areas of hard skin:	
Colour:	
Flexibility:	
Temperature:	
Swelling /puffiness:	
Odour:	
Foot position:	
Nail condition:	
Skeletal structure/arches of the feet:	

Treatment plan:

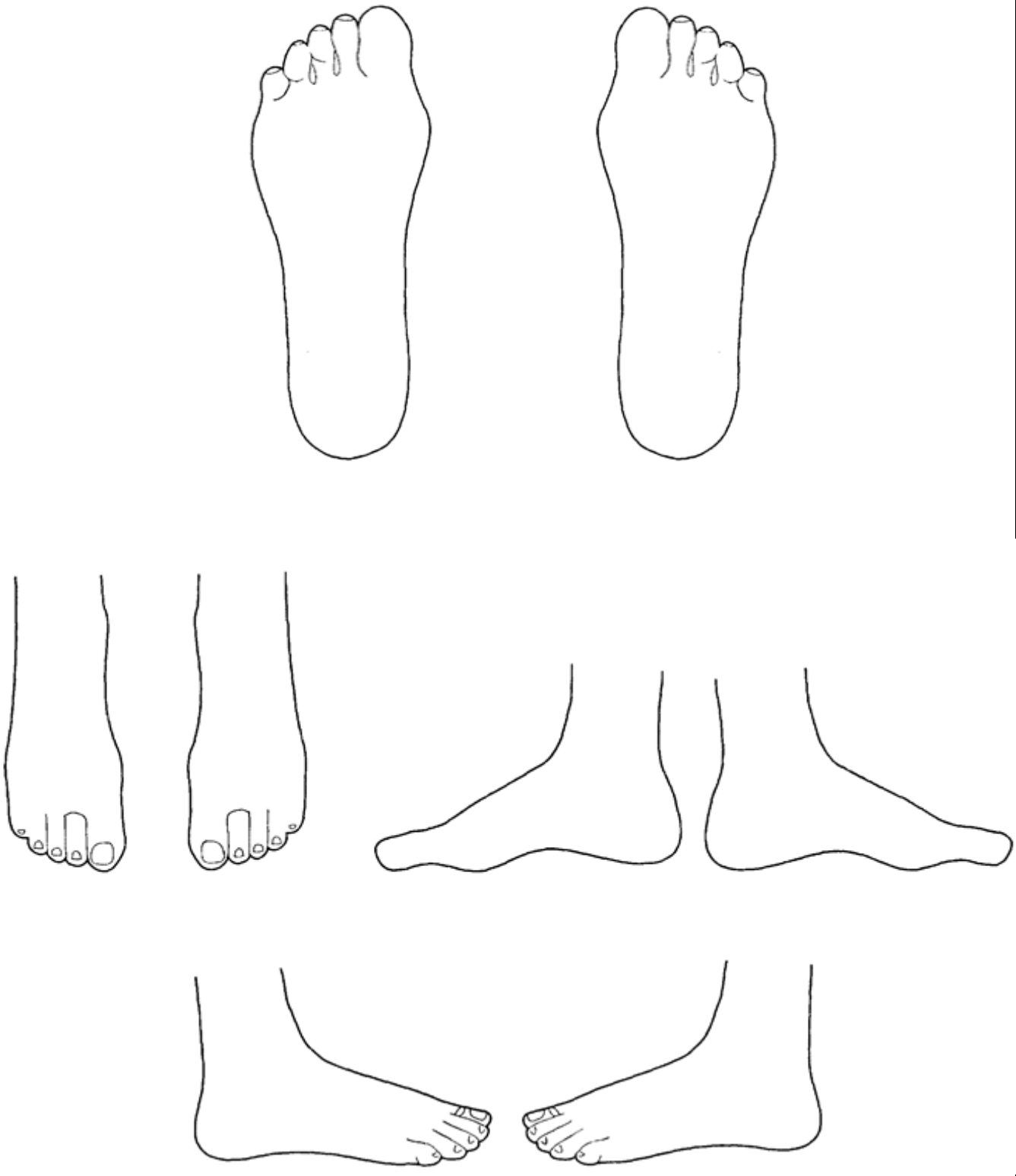
Client feedback:

Aftercare feedback:

Self-reflection and evaluation of the treatment– *(this field to be completed for case studies only):*

Any CPD requirements: – *(this field to be completed for case studies only on conclusion of treatment programme):*

iUCT32 – Provide reflexology for complementary therapies – *Treatment No:*



Client name:	
Treatment date:	

Therapist/learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	09/10/2019	First published	Qualifications and Regulation Co-ordinator
v2	10/01/2020	Re-published	Qualifications and Regulation Co-ordinator