



The Foxwell centre
of holistic therapies

Maternity Reflexology Questionnaire

Conception

Name:

Age:

Address:

Tel:

1. Information

How long have you been trying to conceive?

Have you or your partner had any investigations?

Yes/No

If so what?

Have you ever conceived before?

Yes/No

Are your periods regular?

Yes/No

Have you tried to find out when you ovulate?

Yes/No

When was your last period?

2. Lifestyle

Any medical conditions?

Any medication?

Work:



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Family support:

Stress levels:

Low/Medium/High/Very high

Exercise:

Relaxation:

Diet:

Supplements:

Water intake:

Caffeine:

Alcohol:

Recreational drugs:

Do you suffer from constipation or diarrhoea?

Yes/No

Constipation/Diarrhoea

3. Partner information

How would you describe your partners lifestyle?

Anything else you feel I should know about?