



*The Foxwell centre
of holistic therapies*

Maternity Reflexology Questionnaire

Pregnancy

Name:

Age:

Address:

Tel:

Due date:

No. weeks pregnant:

Hospital care:

1. This pregnancy

Is this a planned pregnancy?	Yes/No
Was this pregnancy conceived naturally?	Yes/No
Is this your first pregnancy? (if not complete Section 2)	Yes/No
Have you had a scan?	Yes/No
If Yes, was this all normal?	Yes/No
Any other tests?	Yes/No



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Do you have any of the following:

Backache	Yes/No	Haemorrhoids	Yes/No
Groin pain	Yes/No	Low blood pressure	Yes/No
Braxton Hicks contractions	Yes/No	High blood pressure	Yes/No
Vaginal bleeding	Yes/No	Oedema	Yes/No
Morning sickness	Yes/No	Panic attacks	Yes/No
Heartburn	Yes/No	Carpal tunnel syndrome	Yes/No
Constipation	Yes/No	Sciatica	Yes/No
Diarrhoea	Yes/No	Headaches	Yes/No
Cystitis	Yes/No	Tender breasts	Yes/No
Palpitations	Yes/No	Fatigue	Yes/No
Anaemia	Yes/No	Diabetes	Yes/No
Leg cramps	Yes/No	Insomnia	Yes/No
Varicose veins	Yes/No	Any other problems	Yes/No
Deep vein thrombosis (DVT)	Yes/No		

2. Previous Pregnancies

Have you ever had a miscarriage? Yes/No

If Yes - how many weeks?

Have you ever had any terminations of pregnancies? Yes/No

If Yes – when?

How many previous pregnancies?	1	2	3	4	5	6
Was the pregnancy normal?						
Did you suffer any ailments?						
Was the baby on time?						
Were you induced?						
Was the delivery normal?						
Did you have any postnatal problems?						

