



The Foxwell centre
of holistic therapies

General Reflexology Questionnaire
Health & Lifestyle

Full Name:	Date:
Address:	GP Name / Address:
D.O.B / Age:	Telephone Number:
Emergency Contact Details Name: Relationship: Telephone Number:	Children: Yes/No Ages:
Occupation:	Height:
Single/ Married/Partner/ Divorced/Widowed	Weight

Reason for reflexology visit:

Past Medical History

Medication (include Herbal remedies, vitamins etc..)	Allergies (Food, medicine, other..)



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Current Medical Conditions / Health Status

Examples:- Skin problems Asthma, bronchitis.. Sinusitis Migraines / Headaches Hayfever	
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Past Surgery

Operations – dates / effects :-
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Significant Injuries / Musculoskeletal problems

Examples :- Fractures / broken bones Back problems Muscle and ligament strains Road Traffic Accidents Neck problems Head injures	Your injuries / muscular skeletal problems :-
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Disabilities

Disabled: Yes/No Physical / Mental	Aids used/support required:
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Women

Last Menstrual Period:	Regularity / Nature of periods:
Pregnancy: Yes/No	Breast Feeding: Yes/No
PMT: Yes/No	Menopausal symptoms: Yes/No



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General

Contact Lenses: Yes/No Glasses: Yes/No	Insertions: Example- Pacemaker, Coil, false limbs...
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Lifestyle

Smoker: Yes/No	Alcohol / Recreational Drugs: Yes/No
Hobbies / Interests:	Child Care / Care of others: Yes/No
Sleep routine / problems:	Exercise: (Type / what)

Do you suffer with Anxiety / Stress / Tension / Depression

Describe how this effects you: Any bereavements/ phobias/ traumatic events / work and family worries...
