CONFIDENTIAL

MATERNITY REFLEXOLOGY

CONSULTATION FORM

SECTION A - *Complete this section if you are a new customer, or if you have NOT filled out this section on another consultation form previously.*

Name:

Mobile:

Landline:

Email:

Occupation:

DOB:

Age:

Doctor/GP:

GP Address:

Address:

Height:

Weight:

Do you Smoke? Y ☐ N ☐

Daily Quantity:

GP Tel:

SECTION B - *Please complete this section*

How many weeks pregnant are you?

When is your medically advised due date?

Have you had any problems with previous pregnancy or delivery?

List and provide dates of any injuries you have had in past 5 years:

List and provide dates of any operations you have had:

Do you have any of the following? *(Tick all that apply):*

☐ Diabetes	☐ Migraine	☐ Epilepsy	☐ Bladder Issues	☐ Blood Pressure	☐ Heart issues	☐ Panic Attacks
☐ Allergies	☐ Asthma	☐ Hepatitis	☐ Skin Problems	☐ Varicose Veins	☐ Depression	☐ Thrombosis/ Phlebitis
☐ Pelvic pain	☐ Low iron	☐ Oedema	☐ Constipation	☐ Hypothyroid	☐ Hyperthyroid	☐ Heartburn

Any other health condition you are being treated for medically:

List medication or complementary supplements / vitamins etc. that you are currently taking:

Do you have any allergies to products? Yes ☐ No ☐ Do you suffer from Anaphylactic shock or carry an Epi-Pen? Yes ☐ No ☐

If you answered "Yes" to the above, please give details below:

Have you ever been treated / hospitalised for any form of psychological illness? Yes ☐ No ☐ If you answered "Yes", please give details below:

Have you any special care needs? Yes ☐ No ☐ If you answered "Yes" please give details below:

If you would like to provide any additional infornation, please use the space below:

SECTION C - *Complete this section if you are a new customer, or if you have NOT filled out this section on another consultation form previously.*

Please provide us with two contacts in case of an emergency. Thank you.

	EMERGENCY CONTACT 1		EMERGENCY CONTACT 2
Name:		Name:	
Mobile:		Mobile:	
Town:		Town:	
Relationship to you:		Relationship to you:	

SECTION D - *Please complete this section*

By signing this document, I attest to the truthfulness and completeness of the information provided in this form /consultation, to my therapist regarding my health. I hereby declare that I have not withheld any information that may affect the outcome of the treatment. The treatment has been fully explained and I have been made aware of any possible reactions which could occur. I hereby indemnify therapist, **Denise Coleman** against any adverse reactions that I may feel are sustained as a result of the treatment.

I give permission to this therapist to hold my records: **A)** to best deliver their services ☐ **B)** to confirm appointments ☐ *(Please tick both boxes)*

I acknowledge that typing my name below constitutes my electronic signature and signifies my consent to the terms and conditions outlined above.

Client Signature: **Date**:

Please complete the form and either email it to info@denisecoleman.com or bring a printed copy to your initial appointment. Failure to do so may result in the inability to proceed with treatment.

PREGNANCY MEDICAL DISCLAIMER FORM

Please read carefully and only sign if you are in full agreement with its contents

I, _____ *(client's name)*

confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or Consultant.

I understand that it is my responsibility and not that of the therapist, to consult my GP or Consultant.

I acknowledge that it is my duty to inform the therapist of any medications or medical conditions pertaining to me, and to update my therapist if anything changes during subsequent treatments.

I confirm that I will inform my therapist, **Denise Coleman** of any significant diagnoses and changes in my pregnancy before the start of each treatment.

Complementary care:
I acknowledge that holistic therapy treatment is complementary and not a replacement for medical or psychological care. I understand that **Denise Coleman** is a holistic therapist and is not a medical provider. I acknowledge that she does not diagnose physical or psychological illnesses, or provide care for medical or psychological emergencies. It is recommended that you receive appropriate health care and follow the advice of your medical health care provider at all times.

I accept and understand that this holistic Reflexology treatment can have no adverse effects on my health, my pregnancy and any current or past medical procedures or treatments. I hereby indemnify therapist, **Denise Coleman** against any adverse reactions that I may feel are sustained as a result of the treatment.

I acknowledge that **Denise Coleman** abides by the ethics codes of the Irish Reflexologists' Institute.

I acknowledge that typing my name below constitutes my electronic signature and signifies my consent to the terms and conditions outlined above.

Client Signature: **Date:**

Therapist Signature: **Date:**

PLEASE NOTE:

Please complete the form and either email it to info@denisecoleman.com or bring a printed copy to your initial appointment. Failure to do so may result in the inability to proceed with treatment.