REFEXOLOGIE QUESTIONAIRE

BALANCING MIND & BODY
EQUILIBRE

All information given will be treated in the strictest confidence.

Name: _ Date of birth: _ _ _ _ _ _ _

Contact numbers: _

e-mail address: _

Occupation: _ _ _ _ _ _ _ _ _ _ _ _ Sports /Hobbies: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Energy Levels: high / medium / low Stress Levels: high / medium / low

Exercise: What type? …… Number of hour/ times a week ……

Height: …… Weight: …… Vision: ….……

Usual blood pressure (if known): …… Non smoker/ smoker

Reason for Reflexology treatment: ……

Average hours sleep per night: …… Do you wake feeling refreshed? .....

Is your sleep disturbed? ……..

DO YOU SUFFER FROM ANY OF THE FOLLOWING: If yes please specify

- Aches and pains …….
- Headaches ……...
- Digestive troubles ……..
- Urinary problems …….
- Endocrine problems ……

Any illnesses that run in your family. Please specify…….

Have you had any surgical intervention? Please specify…….……

Are you currently taking any medication/supplements? ……..

Are you receiving any other forms of treatment? …….

Please add any other information you may feel is relevant …….