

## REFLEXOLOGY or FOOT MASSAGE TREATMENT PLAN

<b>Therapist Name:</b>	<b>Salon Address:</b>	<b>Start Time:</b> <b>Finish Time:</b>	<b>Treatment</b>
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**Client Name:** \_\_\_\_\_ **Date Of Birth:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Proposed Treatment:** Reflexology / Foot massage & lower leg

**Treatment Dates**


**Related Medical History** (conditions that may restrict or prohibit treatment application)

**Are You Taking Any Medication** (this may affect the condition of the skin or skin sensitivity)

<b>CONTRA-INDICATIONS REQUIRING MEDICAL REFERRAL</b> (Preventing reflexology treatment) <b>Yes/No</b>	<b>CONTRA-INDICATIONS WHICH RESTRICT TREATMENT</b> (Treatment may require adaptation) <b>Yes/No</b>
Skin Disorders/Diseases - Active	Mild Skin Disorders
High or Low Blood Pressure	Recent Scar Tissue (Avoid Area)
Severe Varicose Veins	Cuts And Abrasions
Recent Scar Tissue	Undiagnosed Lumps, Bumps, Swellings
Heart Disease	Asthma
Dysfunction of the Nervous System	Product Allergies
Dysfunction of the muscular system	Certain Medications
Severe Bruising	Menstruation
Epilepsy	Migraine
Diabetes	Pregnancy (if yes duration)
Radio therapy/ chemo therapy	Alcohol/drugs
<b>GP Referral:</b>	Sensitivity test

**If you have answered yes to any of the above please give details:**

TREATMENT AREA	GENERAL REASON/OBJECTIVES FOR TREATMENT
<input type="checkbox"/> Feet	<input type="checkbox"/> Relaxation <input type="checkbox"/> Stress relief <input type="checkbox"/> Uplifting/stimulation <input type="checkbox"/> Balancing <input type="checkbox"/> Other _____

NOTE: Please do not fill the green areas.

<p style="text-align: center;"><b>LIFESTYLE</b></p> <p>Health <span style="float: right;">Good/Average/Poor</span></p> <p>Exercise Habits <span style="float: right;">Good/Average/Poor</span></p> <p>Dietary and Fluid Intake <span style="float: right;">Good/Average/Poor</span></p> <p>Sleep Patterns <span style="float: right;">Good/Average/Poor</span></p> <p>Do you smoke/Vape <span style="float: right;">Yes/No</span></p> <p>Do you drink alcohol <span style="float: right;">Yes/No</span></p> <p>Hobbies, Interests, means of Relaxation <span style="float: right;">Yes/No</span></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><b>PHYSICAL CHARACTERISTICS</b></p> <p>Client Range <span style="float: right;">Young/Middle/Elderly</span></p> <p>Skin Type <span style="float: right;">Normal/Dry/Oily/Combination</span></p> <p>Muscle Tone <span style="float: right;">Good /Average/ Poor</span></p> <p>Other _____</p> <hr/> <p style="text-align: center;"><b>PREPARATION OF CLIENT</b></p> <p><input type="checkbox"/> Establish treatment expectations</p> <p><input type="checkbox"/> Jewellery/ clothing removal</p> <p><input type="checkbox"/> Assist client into correct position</p> <p><input type="checkbox"/> Ensure client comfort/modesty/privacy</p>		
<p style="text-align: center;"><b>MASSAGE MEDIUM USED</b></p> <p><input type="checkbox"/> Oil</p> <p><input type="checkbox"/> Cream</p> <p><input type="checkbox"/> Powder</p> <p><input type="checkbox"/> Essential Oils Blending _____</p> <p>_____</p>	<p style="text-align: center;"><b>MASSAGE TECHNIQUES</b></p> <p><input type="checkbox"/> foot holds/support <span style="float: right;"><input type="checkbox"/> relaxation techniques</span></p> <p><input type="checkbox"/> thumb/finger walking <span style="float: right;"><input type="checkbox"/> rotation</span></p> <p><input type="checkbox"/> hook and back up <span style="float: right;"><input type="checkbox"/> rocking</span></p>		
<p><b>CONTRA-ACTIONS:</b></p>		<p><b>MESSURES TAKING IN PLACE:</b></p>	
<p><b>AFTERCARE/HOMECARE</b></p> <p><input type="checkbox"/> Self-treatment <span style="float: right;"><input type="checkbox"/> Relaxation</span></p> <p><input type="checkbox"/> Posture <span style="float: right;"><input type="checkbox"/> Breathing</span></p> <p><input type="checkbox"/> Further treatments <span style="float: right;"><input type="checkbox"/> Products</span></p> <p><input type="checkbox"/> drink water <span style="float: right;"><input type="checkbox"/> eat a light diet</span></p> <p><input type="checkbox"/> avoid alcohol <span style="float: right;"><input type="checkbox"/> reduce caffeine intake</span></p>	<p><b>ADVICE GIVEN:</b></p>		
<p><b>CLIENT CONSENT TO TREATMENT</b></p> <p>All of the information I have given about my medical health is correct and accurate. I am aware that giving false information or withholding details about medical conditions could cause a risk to my health. I have also been advised on how to follow health &amp; safety in the salon including how to mount and dismount the therapy bed.</p>			
<p><b>CLIENT SIGNATURE:</b></p>		<p><b>DATE:</b></p>	
<p><b>THERAPIST SIGNATURE:</b></p>			
<p><b>DATE:</b></p>			

NOTE: Please do not fill the green areas.