CLIENT FEEDBACK FORM

CLIENT's NAME: _____

DATE: _____

Questionnaire

1. RATE HOW STRESSED YOU FELT BEFORE YOUR TREATMENT:
No Stress **1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐** ***Very Stressed***
2. RATE HOW STRESSED YOU FELT AFTER YOUR TREATMENT:
No Stress **1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐** ***Very Stressed***
3. DID YOU HAVE ANY REACTIONS AFTER YOUR LAST TREATMENT?
4. HOW HAVE YOU BEEN FEELING SINCE YOUR LAST TREATMENT?
5. HAVE YOUR SYMPTOMS CHANGED IN ANY WAY?
6. HAVE YOU MADE ANY CHANGES TO YOUR DIET?
7. HAVE YOU MADE ANY CHANGES TO YOUR EXCERCISE ROUTINE?
8. HAVE YOU MADE ANY OTHER CHANGES TO YOUR LIFESTYLE?
9. DO YOU FEEL POSITIVE THAT REFLEXOLOGY WILL HELP?
10. ANY OTHER COMMENTS...