Reflexology Association of Canada
Health Record Guidelines

The following information is a guideline on how to complete the required unsupervised case studies.

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Please prepare 60 Case Studies. These should be completed on a minimum of 6 people with no less than 3 sessions each. Sessions may not include one time sessions due to the practical exams focus on follow-up and progress evaluation with the client. Your case studies must be placed in a binder in alphabetical order. Documentation will be screened for thoroughness in charting practice, progress reports and follow-up. All forms must be printed and in a readable format.

The Health Form This form is required to complete for all persons you wish to use for your practicum. Please note the following:

- All contact info must be recorded.
- For confidentiality reasons, the client must be informed that their information will be reviewed by at least 2 other persons.
- All fields must be completed first by the client then by the student in a different colored ink to differentiate between client and student. No question should be left unanswered or blank. Please put N/A if not applicable and a comment if the client did not wish to answer the question or did not know the answer etc.
- Written explanations must accompany all answers on the form. As an example - question 7. List surgeries, dates, treatments received, medication, any problems associated with the condition or other treatments received. This would be the same for question 8. Question 9 should list the medication names, why they are being used and any side affects associated with them. Question 10 – explain why they are not sleeping well and what this might be associated with. Question 11, 12 – give explanations for the problem and what has been done to date to rectify the matter. Question 15 – list conditions and what is being done for them. All questions should be asked thoroughly and followed-up with more questions to gather as much information about the client as possible.
- Other possible questions to be asked and notated:
    - How does this affect you – the symptoms?
    - When did it start (date if possible)?
    - Where does it bother you?
    - If it is pain, what kind of pain is it – sharp, dull, an ache, etc., and its intensity?

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  - How long do the symptoms last – are they periodic, continuous, vary in intensity?
  - Is there anything that you have observed to trigger the symptom?
  - Are you bothered by this often?
  - Have you found anything that relieves the symptoms?

- For the above reason, a separate page for notes for each question should be attached to the Health Form. Notes will be assessed by the examiner for insight on how well the practitioner understands and is able to gather information to be used for developing the treatment plan.

Session Documentation (How to Document a Session) Please prepare a glossary of all symbols you will use for notation on your session form. This should go in front of your first health record. Symbols are used to denote conditions and anything seen out of the ordinary.

The initial session/treatment form is found on page 4. In assessing the foot for conditions of the feet and for anything that is out of the ordinary, you will note these on this form in symbol form and long hand where no symbol is available. Please see the document entitled 'Reflexology Assessment and Observations'.

To evaluate pressure, please use the standard medical model pain scale rating of 0-5 or 0-10 method with 0 being the least amount of tenderness and 5 or 10 being the upper end of tenderness.

Below is an outline of what is expected for each session:

- Notes will accompany each session diagram. These notes will consist of the questions fond on the session forms and any additional questions you may have noted.
- Initial notes should also contain information on treatment plan to follow and subsequent session notes should show evaluation of the treatment plan as the client progresses.

Order of Documentation

1. Glossary of Symbols
2. Health Record
3. Notes for Health Record
4. Initial Session Form
5. Notes for Session
6. Subsequent sessions with notes

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Additional Notes on Charting Procedures

The assessment provides the foundation for designing and performing a professional safe, knowledgeable, and effective treatment. It provides attention to safety issues, which include support and care of the client. It is a way of drawing inferences from what is seen so that a conclusion may be drawn on how to proceed. In the case of the Reflexologist, it is a skill gained to gather information from the client to identify areas of the foot/hand/ear and related body areas that require more emphasis and specific application of techniques. Practitioners should:

- Know the reasons for assessment and keeping detailed records of treatments
- Know the definitions and symptoms relating to key conditions for each system of the body and have a working knowledge of disorders and conditions of the foot, hand, and ear, and identify relevant reflexology reflexes for each one
- Know how to identify contraindications and how to address each one
- Recognize acute, chronic and degenerative stages of the stress/disease process
- Know how to give appropriate recommendations from the info provided

Reflexology assessment includes

- Taking a health history
- Observation of tactile/palpation, sensory, visual cues based on 'reflex areas'. Follow generally established profession procedures and guidelines on this.

Assessments should consider the value of referring on to other professionals for conditions that cannot be assessed or if the need for a referral is indicated in the assessment or re-assessment.

Practitioners should talk in general terms referring only to reflex areas only not specific organs or body parts as it could be construed as diagnosing. Never only, address a specific problem in treatment. Assessment in reflexology is of the body as a whole. Vocabulary is essential. The use of words such as patient, treatment, heal, cure should be avoided and proper documentation language should be employed

Use of anatomical terms, directional terms, and reflex area is essential when describing location of pathology. Always quote what the client says about how they feel as often as possible rather than making the statement yourself. Use proper abbreviations if choosing to do so.

Structural distortions to the foot can cause a number of conditions including: poor circulation, congestion in energy flow, possible organ problems as the body's center of gravity changes, foot deformities – corns, calluses, bunions, tired, aching, swollen feet and ankles, weakened immune system, headaches and neck pain to name but a few. Knowing how to identify foot anomalies allow us to draft a treatment plan that will benefit the client.

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II What to Look for – Discovery & Exploration

The art of Observation follows a five-step process

1. Gathering Information – Discovery, exploration and assessment
2. Defining the Key Points - Tracking patterns and links and develops client awareness
3. The Plan of Action – Treatment plan development consisting of techniques relevant to findings and give effective results to meet the clients overall goals and expectations
4. Perform – Application of the techniques
5. Evaluate – Record the plan and once applied, evaluate it for future sessions.

Observation and assessment starts as soon as the person walks through the door. The main goal is to look for anything that stands out or apart from the ordinary. Some things to look for include:

1. Medical Diagnosed external and internal factors
2. Chosen Lifestyle patterns – diet, foot ware, habits, occupation, age factors etc.
3. Stress patterning and modification including:
    - Structure
    - Postural patterns – foot structure
    - Gait patterns
    - Wear and tear – normal and abnormal
    - Range of motion
4. Verbal and non-verbal observations including body language
5. Visual and tactile observations
    - Foot and toenail disorders
    - Infections
    - Nail quality
    - Skin abnormalities
    - Temperature
    - Color of feet
    - Circulation
    - Muscle tonus and touch sensitivities
    - Stress adaptations
    - Zone and meridian findings
6. Reflex sensitivities
7. Other: Odor

III Questions To Ask About It

1. Where is it located and what reflex locations are involved?
2. What is it?
3. Why is it there?
4. When - how long has it been there?
5. What does it sound, feel, and look like?

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IV Additional Observations & Questions:

- Compare and contrast one foot to the other
- Consider the overall stress patterns of all clues found
- Are they all at the same level, what are the differences, what are the common traits?
- Which systems or reflexes are prominent?
- Are they mostly in one area?
- Ask questions of clients of a broad nature to complete the information
- Note symptoms and conditions experienced by client

Remember to see the person in the context of their environment. Look to see how they interact with it on the mental, emotional, physical, and spiritual/intuitive planes ***- the holistic approach.***

V How Do You Use This Information? Defining the Key Points and the Plan of Action

Once you have completed an assessment, a treatment plan is drawn up which would include:

- A Session Document noting observations for future reference and progress chart
- A Treatment Summary or General Summary noting:

1. Known and medical diagnosed conditions
2. Lifestyle inhibitors
3. Key systems and pathologies/findings
4. Key reflexes for attention
5. Key meridians and pathologies/findings
6. Treatment techniques
7. Recommendations for
    - Frequency of follow-up sessions
    - Self-help (nutrition, water intake, exercise, footbaths etc.)
    - Other therapies that may be of value
8. Overall comments

Remember your charts are professional and legal documents.

If you require any assistance with the above, please contact your Association and they will be pleased to assist you.

Reflexology Association of Canada Professional Certification & Training

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