A4TS REFLEXOLOGY

Name: _____ Date: ___/___/20___

- ✓ **All you're currently experiencing (C) &/or have experienced in the past (P).**
- ✓ _____Acne
- ✓ _____Anemia
- ✓ _____Appendicitis
- ✓ _____Arthritis
- ✓ _____Asthma
- ✓ _____Bursitis
- ✓ _____Bronchitis
- ✓ _____Carpal Tunnel Syndrome
- ✓ _____Cataracts
- ✓ _____Chronic Fatigue Syndrome
- ✓ _____Colitis
- ✓ _____Constipation
- ✓ _____Cystitis
- ✓ _____Depression
- ✓ _____Diabetes
- ✓ _____Ears
- ✓ _____Edema
- ✓ _____Epilepsy
- ✓ _____Eye Problems
- ✓ _____Fever
- ✓ _____Fainting
- ✓ _____Gall Stones
- ✓ _____Headaches
- ✓ _____Heart Problems
- ✓ _____Hiccoughs
- ✓ _____Hypertension
- ✓ _____Hypoglycemia
- ✓ _____Incontinence
- ✓ _____Kidney Stones
- ✓ _____Lung Disorders
- ✓ _____Menstrual Cramps
- ✓ _____Migraines
- ✓ _____Nausea
- ✓ _____Perspiring Hands &/or Feet
- ✓ _____Pneumonia
- ✓ _____Pregnancy
- ✓ _____Prostate Problems
- ✓ _____Sciatica
- ✓ _____Sinusitis
- ✓ _____Stroke
- ✓ _____Varicose Veins
- ✓ _____Vertigo
- ✓ _____Whiplash