

Reflexology Health Record

Note: This form to be completed on the first visit only.

Name: _____

Today's Date: _____

(Month/Day/Year)

Address: _____

Tel. Res: () _____

Town: _____

Tel. Bus: () _____

Prov./State: _____ PC/Zip: _____

Birth Date: _____

(Month/Day/Year)

Last Medical Visit: _____ Findings (Medical): _____

Have you had any accidents? No Yes What/When? _____

Do you have any serious illness? No Yes What/When? _____

Have you been hospitalized recently? No Yes Why/When? _____

Have you had any broken bones? No Yes What/When? _____

Have you had any surgery? No Yes What/When? _____

Are you on medication? No Yes What/Why? _____

Do you have any heart problems? No Yes What/When? _____

Do you have a pacemaker? No Yes Where/When? _____

How is your blood pressure? Normal Not Normal Why? _____

Do you have any circulatory problems? No Yes What? _____

Are you pregnant? (female only) No Yes Trimester? _____

Any history of cancer? No Yes What/When? _____

Do you have diabetes? No Yes What/When? _____

Do you have epilepsy? No Yes What/When? _____

Do you wear any prostheses?
(artificial limbs, hearing aids, etc) No Yes What/Where? _____

Do you smoke / have allergies? No Yes What/When? _____

Are you taking other therapies? No Yes What? _____

Have you had Reflexology before? No Yes Who/When? _____

Who referred you to us? _____ What is your occupation? _____

Who is your doctor? _____ Doctor Tel. #: _____

Present _____

Problems: _____

Consent for Reflexology Session:

I understand and accept that the sessions received are of therapeutic value only and fully accept responsibility for the same.

Signature: _____
(parent/guardian)

Date: _____