Reflexology Health Record

Date: _____
Name:_____
Date of Birth:_____
Address:_____
_____
_____
_____

City: _____
Province: _____ Postal Code: _____
Email: _____
Phone Number (H): _____
(W)_____

1. Are you undergoing any other therapies? Yes ✎ No ✎
   If yes, please

2. What are your objectives/expectations for this session?
   _____
   _____

3. Are you taking medications (vitamins, dietary supplements)? Yes ✎ No ✎ If yes, please list:

_____

_____

_____

4. Do you sleep well? Yes✎ No✎ If no, Please explain:

_____

_____ _____

5. Do you suffer from anxiety or worry? Yes ✎ No ✎
Please Explain

_____

_____ _____

6. Is your blood pressure: Normal✎ High✎ Low✎
Stable✎ Erratic✎

_____

7.Are you pregnant? Yes ✎ No ✎ If yes, which trimester? _____

8.Have you had other pregnancies? Yes✎ No✎ If yes, were there complications?

_____

Date of last period_____

9. Do you have allergies/sinus conditions? Yes ✎ No ✎ If yes, explain:

_____

_____

10. Do you wear prostheses? (eg. Glasses, contacts, glass eye, artificial joint/limb, metal plate, pins or wires, dentures, hearing aid) Yes✎ No✎ If yes, list:

_____

_____

Do you or have you ever had problems with the following: Please check

Conditions:	Yes, if so what	No	Unsure
Cardiovascular			
Reproductive issues eg.			
Lung			
Eye Problems			
Foot problems			
Lymphatic or			
Cancer			
Diabetes			
Urinary			
Endocrine eg. Menopause,			
Integumentary System eg. Skin			
Digestive			
Musculoskeletal			
Respiratory			
Mental Health			

Consent:

I, the undersigned, consent to reflexology treatment and understand that the sessions are for stress reduction and relaxation. Reflexology does not substitute for medical examination, diagnosis, or treatment and I will consult a physician, or other qualified medical specialist for all my mental or physical ailments of which I am aware. I may stop the session at any time, either during the assessment or the treatment. Reflexology therapists do not diagnose, prescribe, treat for specific conditions or use tools of any kind. I confirm that I have informed the therapist of my known medical conditions and answered all questions honestly. Should I seek further reflexology treatment from the therapist, I agree to update them as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Client
Signature:_____

Date: _____