R.A.C. A.C.R.
REFLEXOLOGY ASSOCIATION OF CANADA
ASSOCIATION CANADIENNE DE RÉFLEXOLOGIE

HEALTH RECORD

Date: ______________________ Name: ________________________________ Date of Birth: ______________________

Address: ____ City: ______________________

Province: ______________ Postal Code: _____________ Email: ____

Phone Number (H): ______________________ (W): ________________________ (C): ________________________

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1. What is your occupation? ____
2. Are you in good health? Yes ❑ No ❑ If no, explain: ____
3. Are you undergoing other therapies? Yes ❑ No ❑ If yes, list: _____________________________________

   What else are you doing for your health? ____
4. What are your objectives/expectations for this session? ____
5. When did you last visit your doctor? ____

   Reason: ____
6. List past surgeries/injuries and time of same: ____
7. Are you taking medications (vitamins, dietary supplements)? Yes ❑ No ❑

   If yes, list: ____
8. Do you sleep well? Yes ❑ No ❑ If no, explain: ____
9. Do you suffer from anxiety or worry? Yes ❑ No ❑ Explain ____________________________________
10. Is your blood pressure: Normal ❑ High ❑ Low ❑ // Stable ❑ Erratic ❑ Explain: ___________________
11. Are you pregnant? Yes ❑ No ❑ If yes, which trimester? ____

    Have you had other pregnancies? Yes ❑ No ❑ If yes, were there complications? ____________________
12. Do you have allergies/sinus conditions? Yes ❑ No ❑ If yes, explain: _______________________________
13. 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: ____
14. Are there any current problems with your health? Explain: _______________________________________
15. Is there anything else about your health you wish to discuss? ____________________________________

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.

Signature: ____ Date: ______________________

Reflexology Association of Canada
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HEALTH RECORD

Are you presently experiencing any of the following?

Sunburn	❑	Inflammation	❑
Pain	❑	Headache	❑
Skin rash	❑	Cuts, bruises, burns	❑
Colds/Flu	❑	Decreased range of motion	❑

Other ______________________________________

Indicate your consumption/activity level of the following:

	NONE	LIGHT	MODERATE	HEAVY
Salt	❑	❑	❑	❑
Sugar	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Alcohol	❑	❑	❑	❑
Water	❑	❑	❑	❑
Exercise	❑	❑	❑	❑

Check the appropriate answer:

ENDOCRINE SYSTEM:

Diabetes	Yes ❑	No ❑	Past ❑
Hypoglycemia	Yes ❑	No ❑	Past ❑
Menopausal Problems	Yes ❑	No ❑	Past ❑
Hypothyroidism	Yes ❑	No ❑	Past ❑
Hyperthyroidism	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

URINARY SYSTEM:

Kidney Disease	Yes ❑	No ❑	Past ❑
Kidney Stones	Yes ❑	No ❑	Past ❑
Urinary Problems	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

CARDIOVASCULAR SYSTEM:

Heart Disease	Yes ❑	No ❑	Past ❑
Phlebitis	Yes ❑	No ❑	Past ❑
Varicose Veins	Yes ❑	No ❑	Past ❑
Circulation Problems	Yes ❑	No ❑	Past ❑
Anemia	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

IMMUNE & LYMPHATIC SYSTEMS:

Arthritis	Yes ❑	No ❑	Past ❑
Chronic Fatigue	Yes ❑	No ❑	Past ❑
HIV/AIDS	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

MUSCULOSKELETAL SYSTEM:

Osteoporosis	Yes ❑	No ❑	Past ❑
Fibromyalgia	Yes ❑	No ❑	Past ❑
Bursitis	Yes ❑	No ❑	Past ❑
Gout	Yes ❑	No ❑	Past ❑
Back pain	Yes ❑	No ❑	Past ❑
Scoliosis	Yes ❑	No ❑	Past ❑
Foot/Arm/Hand problems	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

RESPIRATORY SYSTEM:

Asthma	Yes ❑	No ❑	Past ❑
COPD	Yes ❑	No ❑	Past ❑
Emphysema	Yes ❑	No ❑	Past ❑
Tuberculosis	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

NERVOUS SYSTEM:

Vision	Yes ❑	No ❑	Past ❑
Hearing loss/Problems	Yes ❑	No ❑	Past ❑
Nerve pain/Damage	Yes ❑	No ❑	Past ❑
Mental Health Issues	Yes ❑	No ❑	Past ❑
MS	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

REPRODUCTIVE SYSTEM:

PMS	Yes ❑	No ❑	Past ❑
Endometriosis	Yes ❑	No ❑	Past ❑
Prostate Problems	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

DIGESTIVE SYSTEM:

Constipation	Yes ❑	No ❑	Past ❑
Diarrhea	Yes ❑	No ❑	Past ❑
Crohn's Disease	Yes ❑	No ❑	Past ❑
Colitis	Yes ❑	No ❑	Past ❑
Diverticulitis	Yes ❑	No ❑	Past ❑
Ulcer	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

INTEGUMENTARY (SKIN) SYSTEM:

Psoriasis	Yes ❑	No ❑	Past ❑
Eczema	Yes ❑	No ❑	Past ❑
Warts	Yes ❑	No ❑	Past ❑

Specify: ______________________________________

OTHER

Hepatitis	Yes ❑	No ❑	Past ❑
Herpes	Yes ❑	No ❑	Past ❑
Cancer	Yes ❑	No ❑	Past ❑

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