Reflexology Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Health Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

Have you had any recent injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

Please rate the following on a scale of 1(bad) – 5(excellent)

Quality of Sleep	1	2	3	4	5
Energy Levels	1	2	3	4	5
Stress Levels	1	2	3	4	5
Quality of Nutrition	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Treatment Information

Have you had Reflexology before? ☐ yes ☐ no

Why are you seeking Reflexology today?

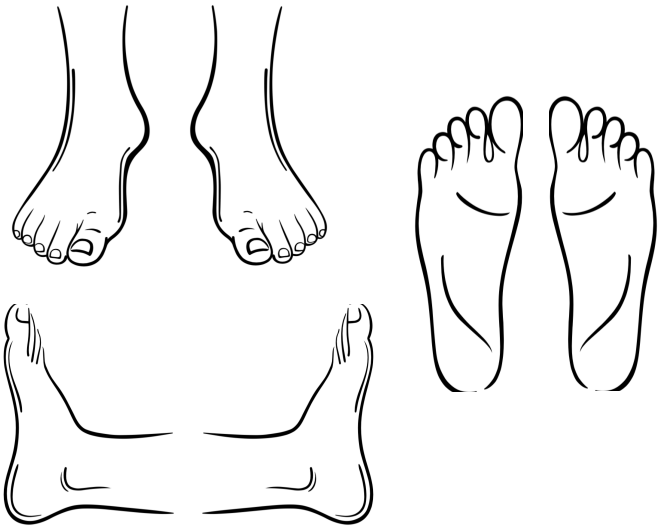
_____

_____

What are your goals for this session?

_____

Please circle any areas of discomfort:



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my Reflexologist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Reflexologist Signature _____ *Date* _____