

Integrative Reflexology™

SESSION



Name: _____

Phone (home): _____ (work): _____

Address: _____

Email: _____

Occupation: _____

Hobbies/Physical Activities: _____

General State of Health: _____

Are you currently taking medications? Yes No

If YES, please list _____

For what condition _____

List any allergies: _____

Have you had any surgeries? Yes No

If YES, please describe _____

Are you currently being treated for any conditions by a physician? Yes No

If YES, please describe _____

Are you receiving care by a holistic health practitioner (acupuncture, chiropraction, bodywork, etc)?

Yes No

If YES, please describe _____

Have you ever received foot and/or hand reflexology? Yes No

If YES, when _____

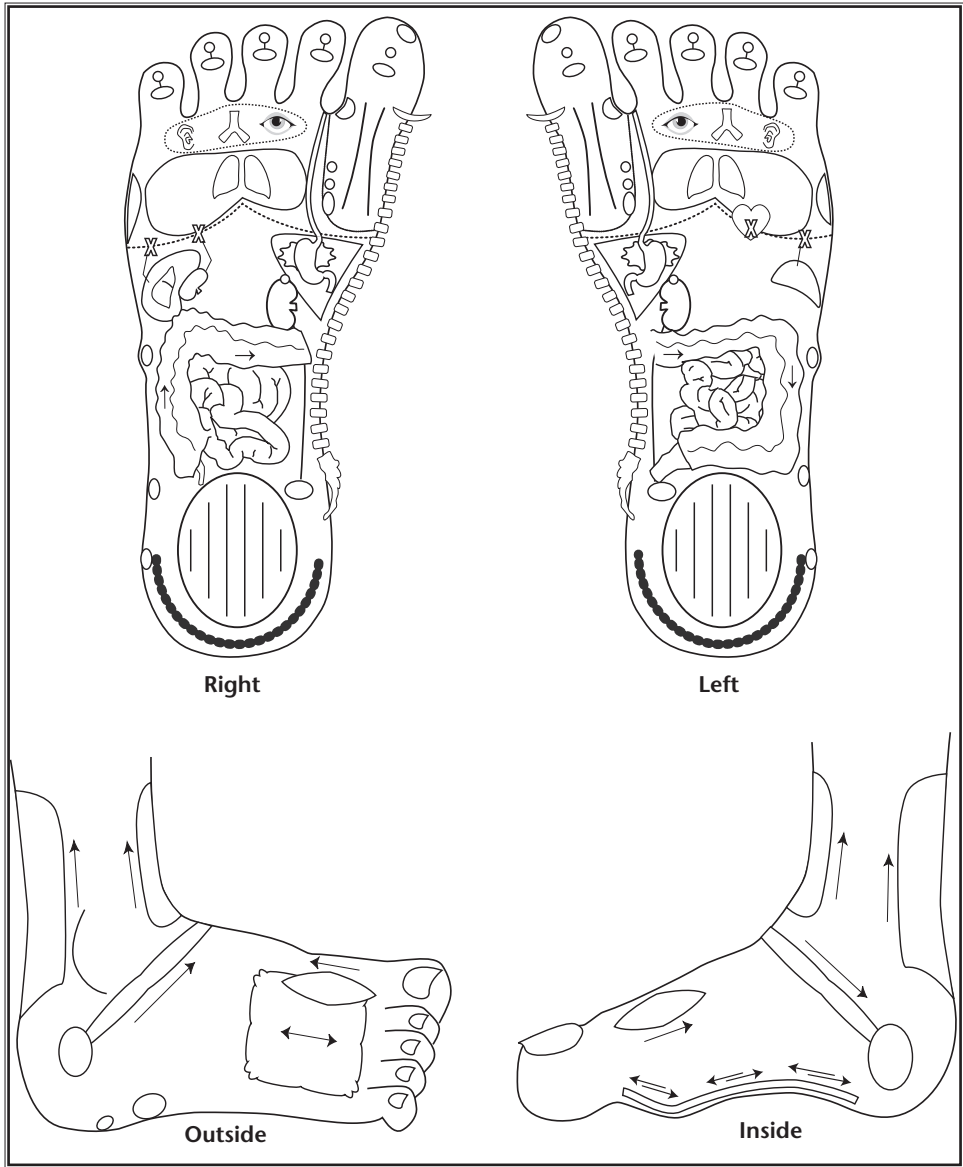
For how long? _____

Any reactions? _____

Do I have your permission to contact you 48 hours after the treatment to record your reaction?

Yes No

Additional Comments:



Observations:

(corns, calluses, bunions, and other foot deviations)

Label Tender Areas 1-5:

1 – Very slight tenderness

5 – Extremely tender

** Best to work at Level 3*

Reactions During Session:

Reactions Immediately After Session: _____

Reactions 24-48 Hours After Session: _____

Client Overall Experience of Session: _____

**Disclaimer: Foot Reflexology does not claim to treat or diagnose physical conditions.
Please refer clients to physician for medical treatment.*