REFLEXOLOGY

Consultation Form

Name _____ Phone _____

Address_____

Occupation _____ Email _____

The following information will be used to help plan a safe and an effective massage session. Please answer the questions to the best of your knowledge.

Have you had reflexology before? ☐ Yes ☐ No

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your stress level right now? ☐ Low ☐ Average ☐ Somewhat Stressed ☐ Very Stressed

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

List current medications & the conditions they are treating:

_____

_____

Please tell us about any allergies or hypersensitivities

_____

_____

Do you have any allergies to oils, lotions, or ointments? ☐ Yes ☐ No

If yes, please explain_____

Do you have sensitive skin? ☐ Yes ☐ No

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

Please rate the following on a scale of:

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

Please mark any areas of discomfort, pain on the image