

Practitioner Name:

Health Information

Contact Information

(page 1 of 2)

Client Contact Information

Client Name: _____ Date: _____
Date of Birth: _____ Gender: _____
Address: _____
Phone: _____ Email: _____
Referred by: _____
Emergency contact: _____ Phone: _____

Reflexology Information

Have you ever received professional reflexology before? Yes No

How recently?

What are your goals/expected outcomes for receiving reflexology?

How do you feel today?

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
Explain:

List the medications you currently take:

Are you pregnant? Yes No

Health History

Have you had any injuries or surgeries in the past that may influence today's session?

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema, open wounds/ulcers, varicose veins

Please answer honestly, as reflexology may not be indicated for the above conditions



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(page 2 of 2)

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

- Current Past Muscle or joint pain
- Current Past Muscle or joint stiffness
- Current Past Numbness or tingling
- Current Past Swelling
- Current Past Bruise easily
- Current Past Sensitive to touch/pressure
- Current Past High/Low blood pressure
- Current Past Stroke, heart attack
- Current Past Varicose veins
- Current Past Shortness of breath, asthma
- Current Past Cancer
- Current Past Neurological (e.g. MS, Parkinson's, chronic pain)
- Current Past Epilepsy, seizures
- Current Past Headaches, Migraines
- Current Past Dizziness, ringing in the ears
- Current Past Digestive conditions (e.g. Crohn's, IBS)
- Current Past Gas, bloating, constipation
- Current Past Kidney disease, infection
- Current Past Arthritis (rheumatoid, osteoarthritis)
- Current Past Osteoporosis, degenerative spine/disk
- Current Past Scoliosis
- Current Past Broken bones
- Current Past Allergies ___
- Current Past Diabetes
- Current Past Endocrine/thyroid conditions
- Current Past Depression, anxiety
- Current Past Memory Loss, confusion, easily overwhelmed

Comments:

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure may be adjusted to my level of comfort. I further understand that reflexology should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that reflexology practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because reflexology should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature:

Date:

Parent or Guardian Signature (in case of a minor):

Date:

