REFLEXOLOGY INTAKE FORM

Full Name: ____ Date of Birth:______________________

Are you in good health? YES / NO   Explain: ____

What are your objectives/expectations for this session?____

Are you undergoing other therapies? YES / NO If NO, List: ____________________________________

What else are you doing for your health? ____

When did you last visit your doctor? Reason? ____

Past Surgeries? List Date/Reason: ____

Do you sleep well? YES / NO If no, explain: ____

How much water do you drink daily? ____________CUPS

Do you suffer from anxiety or worries? YES / NO If YES, explain: _______________________________

Is your blood pressure: NORMAL / HIGH / LOW / STABLE / ERRATIC

Do you have allergies or sinus conditions? YES / NO If yes, Explain:_____________________________

Do you wear prostheses (Ex. glasses, contact lenses, glass eye, artificial joint/limb, metal plate, pins or wires, dentures, hearing aid). YES / NO. If yes, Explain:____

Are there any problems with your health? Explain: ____

Is there anything else about your health you wish to discuss? __________________________________

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(Men: Please continue to next page)

Women Only:

Are you pregnant? YES / NO If yes, List trimester and due date__________________________________

Have you had other pregnancies? YES / NO If yes, were there complications?______________________

Are you presently experiencing any of the following?

	Sunburn		Inflammation
	Pain		Headache
	Skin Rash		Cuts/Bruises/Burns
	Cold/Flu		Decreased Range of Motion

Please indicate your consumption of the following:

	None	**Light**	**Moderate**	**Heavy**
Salt				
Sugar				
Caffeine				
Tobacco				
Alcohol				

Please fill out the following Health History:

	Yes	**No**	**Past**		**Yes**	**No**	**Past**
ENDOCRINE				**URINARY SYSTEM**			
Diabetes				Kidney Disease			
Hypoglycemia				Kidney Stones			
Menopausal Problems				Urinary Problems			
Hyperthyroidism				Other: _______________			
Hypothyroidism				**MUSCULOSKELETAL**			
Other: __________________				Osteoporosis			
CARDIOVASCULAR				Fibromyalgia			
Heart Disease				Bursitis			
Phlebitis				Gout			
Varicose Veins				Back Pain			
Circulatory Problems				Scoliosis			
Anemia				Foot/Arm/Hand Issue			
Other: __________________				Other:_______________			

	Yes	No	Past		Yes	No	Past
RESPIRATORY				**NERVOUS SYSTEM**			
Asthma				Vision			
COPD				Hearing Loss/Problems			
Emphysema				Nerve Pain/Damage			
Tuberculosis				Mental/Emotional Issue			
Other: __________________				Multiple Sclerosis			
IMMUNE & LYMPHATIC				Other:_______________			
Arthirits				**REPRODUCTIVE**			
Chronic Fatigue				PMS			
HIV/AIDS				Endometriosis			
Other: __________________				Prostate Problems			
DIGESTIVE				Other:_______________			
Constipation				**INTEGUMENTARY(SKIN)**			
Diarrhea				Psoriasis			
Crohn's Disease				Eczema			
Colitis				Warts			
Diverticulitis				Other:_______________			
Ulcer				**OTHER**			
Other: __________________				Hepatitis			
				Cancer:______________			
				Herpes			

CONSENT:

I, the undersigned, consent to reflexology treatment, and understand that the sessions are for the purpose of 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 in 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 all 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 part should I forget to do so.

Signature:____ Date:___________________________