Reflexology Intake Form

Name: ____ Date of birth: day______ month______ year__________

Address:__________________________________ Town/City: _________________ Postal Code: _________________

Phone Numbers: (H) ______________________ (M) ________________________ (W) __________________________

E-mail address: ____ (used only for clinic purposes)

How did you hear about us? flyer, drive by, mail, lawn sign, internet, friend ____________________________________

Please fill out the form below, being as honest and thorough as possible.

Primary Physicians name: ____ Phone: ________________________

Are you currently under the care of a health care professional for a specific condition? If yes, for what?

____

Are you taking any medication? ___ Yes ___ No What/Why? ___________________________________

Have you had any surgery? ___ Yes ___ No What/Why? ___________________________________

Have you been hospitalized recently? ___ Yes ___ No What/Why? ___________________________________

Which of the following apply to your health ? Use current (c) or past (p):

____ Allergies	____ High or Low blood pressure	____ Eczema/psoriasis
____ Dizziness/Fainting	____ Heart condition/attack/stroke	____ Athlete's foot
____ Headaches/Migraines	____ Pacemaker	____ Warts
____ Bladder/Urinary tract infections	____ Varicose Veins/phlebitis	____ Bronchitis
____ Broken bones	____ Indigestion	____ Pneumonia
____ Sciatica	____ Constipation/Diarrhea	____ Epilepsy
____ Joint replacement	____ Arthritis	____ Diabetes
____ Fibromyalgia	____ Multiple Sclerosis	____ Cancer

Women only:

____ Pregnant Trimester? ______________

Additional comments or concerns about your health: ____

____

Are you undertaking any other therapies ____ Yes ____ No What ___________________________________

An accurate health history is important to provide the best treatment for you. If your health changes in the future, please inform me. As a holistic practitioner, I do not diagnose, prescribe for or treat any specific illness. Holistic treaments work with the body as a whole.

If you have any medical problems, please seek professional medical help.

The information given above is correct. Any information given is kept fully confidential and private. I herby consent to the session as it has been explained to me and give my permission to proceed.

Signed: ____ Date: _________________________________