Name ____________________ Birthdate ____________________ Age __________
Address ____________________ City ____________ State ______ Zip __________
Home Phone ____________________ Cell ____________ Work __________
Profession ____________________ Employer ____________________
E-Mail ____________________ Referred by ____________________

(Please write in all CAPITAL LETTERs and DIFFERENTIATE the letters i from L, and the letter L from the number 1)

Have you ever had a Reflexology session? __________ If yes, when, how often, results? __________
How do you feel today? ____________________
General health: ○ Excellent ○ Good ○ Fair ○ Poor
Where do you feel tension most in your body? ____________________
What are your goals/expectations for this session? ____________________

Please check the question if the answer is YES:

- ○ Within the past year, have you been under a physician's care?
- ○ Within the past year, are you undergoing other therapies? ○ Acupuncture ○ Massage ○ Chiropractic
- ○ Within the last nine months have you undergone surgery? If so, please specify: ____________________

____

List any medications, supplements & vitamins that you take regularly: ____________________

____

List any allergies that you have ____________________

Check if your answer is YES:

- ○ Exercise regularly
- ○ Follow a restricted diet
- ○ Eat Healthy
- ○ Sleep Well (how many hours) ______
- ○ Coffee/Tea (drinks) ______
- ○ Smoke (packs) ______
- ○ Alcohol (drinks) ______
- ○ Water (drinks) ______
- ○ Pregnant or Nursing (Please circle)
- ○ Birth control or Hormone Replacement
- ○ Claustrophobic or Vertigo
- ○ Problems with your Feet

Please mark (#) for the pain for the conditions that apply now and put a (P) for past conditions
Pain Scale: minor – 1 2 3 4 5 6 7 8 9 severe – 10

______ headaches, migraines
______ fever
______ vision problems
______ hearing problems, deafness
______ injuries to face or head
______ sinus problems
______ dental bridges, braces
______ jaw pain, TMJ problems
______ cold sores
______ asthma or lung conditions
______ bronchitis
______ abdominal, digestive problems
______ constipation, diarrhea
______ autoimmune condition
______ other medical conditions not listed
______ cancer, tumors
______ diabetes
______ hernia
______ hyperthyroid/hypothyroid
______ chronic pain
______ muscle or joint pain
______ muscle, bone injuries
______ numbness or tingling
______ sprains, strains
______ arthritis, tendonitis
______ sciatica
______ spinal column disorders
______ heart, circulatory problems
______ high/low blood pressure
______ blood clots
______ varicose veins
______ pms
______ endometriosis
______ problems mestruating
______ prostate problems
______ athletes foot
______ bunions
______ corns
______ plantar warts
______ fatigue
______ tension, stress
______ depression
______ sleep difficulties
______ rashes
______ psoriasis

Explain any areas noted above: ____________________

____

What are your feelings about your health condition? ____________________

____

What does your body need to heal? ____________________

____

What else are you doing for health? ____________________

Are you sensitive to smells, oils, lotions or creams? ____________________

I understand that the Reflexology I receive is for the reduction of stress, relaxation and to improve circulation. I will immediately inform the Reflexologist so that the pressure can be adjusted to my comfort level. I understand that the services offered are not a substitute for medical care, and any information provided by the Reflexoflogist is for educational purpose only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the Reflexologist in giving better service and is completely confidential. In order to maximize the effectiveness and safety of the sessions together, please participate in exchanging feedback prior, during and at the end of the session. This will help in tailoring the therapeutic session to serve your needs in the best possible way.

We have a 24-hour cancellation policy. We require 24 hours notice of cancellation for all of our appointments or you may be charged a cancellation fee of $20. We value your time – Please value ours.

Client Signature: ______________________________ Date: ______________

Therapist Signature: ______________________________ Date: ______________