Reflexology Health Record

Note: This form to be completed on the **first visit only.**

Name: _____ Today's Date: _____ (Month/Day/Year)

Address: _____ Tel. Res: ( ) _____

Town: _____ Tel. Bus: ( ) _____

Prov./State: _____ PC/Zip: _____ Birth Date: _____ (Month/Day/Year)

Last Medical Visit: _____ Findings (Medical): _____

Have you had any accidents?	No ☐	Yes ☐	What/When? _____
Do you have any serious illness?	No ☐	Yes ☐	What/When? _____
Have you been hospitalized recently?	No ☐	Yes ☐	Why/When? _____
Have you had any broken bones?	No ☐	Yes ☐	What/When? _____
Have you had any surgery?	No ☐	Yes ☐	What/When? _____
Are you on medication?	No ☐	Yes ☐	What/Why? _____
Do you have any heart problems?	No ☐	Yes ☐	What/When? _____
Do you have a pacemaker?	No ☐	Yes ☐	Where/When? _____
How is your blood pressure?	Normal ☐	Not Normal ☐	Why? _____
Do you have any circulatory problems?	No ☐	Yes ☐	What? _____
Are you pregnant? (female only)	No ☐	Yes ☐	Trimester? _____
Any history of cancer?	No ☐	Yes ☐	What/When? _____
Do you have diabetes?	No ☐	Yes ☐	What/When? _____
Do you have epilepsy?	No ☐	Yes ☐	What/When? _____
Do you wear any prostheses? (artificial limbs, hearing aids, etc)	No ☐	Yes ☐	What/Where? _____
Do you smoke / have allergies?	No ☐	Yes ☐	What/When? _____
Are you taking other therapies?	No ☐	Yes ☐	What? _____
Have you had Reflexology before?	No ☐	Yes ☐	Who/When? _____

Who referred you to us? _____ What is your occupation? _____

Who is your doctor? _____ Doctor Tel. #: _____

Present Problems: _____

Consent for Reflexology Session:

I understand and accept that the sessions received are of therapeutic value only and fully accept responsibility for the same.

Signature: (parent/guardian) _____ Date: _____