REFLEXOLOGY CLIENT HISTORY

Name/Client #: ______________________________ Date:______________________

Address: ____

Cell/ Phone: ___________________ Date of Birth: ______________________________

E-mail: ______________________ How did you find out about me? __________________

1. How would you rate the present state of your health? (Excellent Good Fair Poor)
2. What is your level of stress from 1-10 ? _______
3. List all diagnosis, previous illnesses, accidents, surgeries & broken bones and date of occurrence.

____

____

4. Are you pregnant? If yes, how long? ________ Any high risk factors? ___________________
5. Please list any medications and reasons prescribed: ________________________________
   ____
   ____
6. Do you have any allergies? ____
7. Any problems with your feet? If so, what? ______________________________________
8. Do you have tension or pain? (ie neck, stomach) _________________ Pain level 1-10?_______
9. What are your goals for the session? ____

You need to know that I am not a doctor. Reflexology is not diagnostic and is not a substitute for medical treatment, however is a complement to most types of therapy.

By signing this form, I give my consent to a reflexology session. I understand I may discontinue a session at any time and agree to consult a doctor with any contraindications or health concerns.

I have received a copy of the Health Care Client Bill of Rights.

Please respect a 24 notice policy for cancellations to avoid charges

Signature: ______________________________