General Information

Last Name:_____ First Name: _____ D.O.B._____

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Address: _____

City: _____ State:_____ Zip:_____Phone: _____

Email: _____Occupation: _____

Referred by: _____ Date of First Visit: _____

Emergency Contact

Name: _____ Relationship:_____Phone: _____

Lifestyle Management

List any illness or disease that you have: _____

_____

Family history of disease: _____

Are you currently on any medication? Yes ☐ No ☐

If so, please list what you are taking and what it is for: _____

_____

Operations you have had: _____

What does your general diet consists of: _____

Nutritional supplements you take: _____

How well do you sleep? _____

Do you wake up at a certain time each night? Yes ☐ No ☐ If so, what time? _____

Stress factors/management: _____

_____

Do you smoke? Yes ☐ No ☐ If yes, how much and how long?_____

Do you exercise? Yes ☐ No ☐ Allergies and intolerances: _____

Contraindications

1. Are you pregnant? Yes ☐ No ☐
2. Do you have varicose veins? Yes ☐ No ☐
3. Are you currently receiving chemotherapy treatment for cancer? Yes ☐ No ☐
4. Do you have blood clots? Yes ☐ No ☐

What is the primary reason for your session (i.e. aches, pains, relaxation)? _____

_____

Reflexologists do not diagnose, treat a specific disease or illness, interfere with medication or prescribe medication. If you have a specific medical problem or complaint, you are advised to seek professional medical help. You should also discuss any problems or complaints with the therapist if you are unsure whether or not to continue with treatment for whatever reason.

Signed: _____ Date:_____