



Reflexology Client Intake Form

Client Information

Name: _____ Occupation: _____
Date of Birth: _____ Gender: Male Female
Address: _____ Postal Code: _____
City: _____ Province: _____
Daytime Phone #: _____ Evening Phone #: _____
Emergency Contact Name & Phone # _____
Email Address: _____

___ Check here if you would prefer NOT to receive our Wellness e-newsletter

Health History

Have you ever received a Reflexology session before? (circle) Yes No

What is your primary reason for seeking receiving Reflexology? _____

Are you currently under the care of a physician? (circle) Yes No

How would you rate your present state of health? (circle) Excellent Good Fair Poor

Are you pregnant or trying to get pregnant? _____ If yes, how far along are you? _____

Please list any major illnesses, broken bones, surgeries, hospitalizations and your age when they occurred: _____

List any **conventional** or **complimentary** medications, herbs and therapies you are currently trying: _____

List any therapies (besides conventional medicine) you are currently receiving: _____

Where is the most evident spot of tension in your body? (i.e. neck, shoulders, jaw) _____

How do you nurture your Mind, Body and Spirit? _____

Is relaxation a challenge for you? Yes ___ No ___ Comments: _____

*The above information is accurate and true to the best of my knowledge. I understand that no diagnosis is implied or offered. **I agree to give a minimum of 24 hours notice if I must cancel or reschedule an appointment**, and understand that I will be charged the session price without such notice*

Signed: _____ Date: _____



Conditions / Issues

Please check all that you are either experiencing now, or have experienced in the past:

Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: _____

Circulatory/Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: _____

Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: _____

Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: _____

Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: _____

Reproductive System

- Pregnancy:
 - Current
 - Previous
- PMS
- Menopause
- Pelvic Inflammatory Dis.
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems

Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use _____
- Alcohol use _____
- Nicotine use _____
- Caffeine use _____
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease
- _____
- Other congenital or acquired disabilities
- _____
- Other: _____