



Initial Reflexology Health Record

Today's Date: _____ Referred by: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____

Postal Code: _____ Telephone home: _____ Cell : _____

Email: _____

Doctor: _____ Address: _____

Dr.'s Phone _____ Emergency contact: _____

Please describe any current health problems you may have: _____

Are you under a physician's care? _____ For what condition? _____

Check any of the following which are applicable to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> taking any medication | <input type="checkbox"/> trouble sleeping | <input type="checkbox"/> sinus condition |
| <input type="checkbox"/> involved in other therapies | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> skin condition |
| <input type="checkbox"/> past surgeries | <input type="checkbox"/> severe headaches | <input type="checkbox"/> arthritic |
| <input type="checkbox"/> past serious accident | <input type="checkbox"/> heart condition | <input type="checkbox"/> menstrual problems |
| <input type="checkbox"/> past serious illness | <input type="checkbox"/> abnormal blood pressure | <input type="checkbox"/> menopausal problems |
| <input type="checkbox"/> diabetic | <input type="checkbox"/> allergies | <input type="checkbox"/> currently pregnant |
| <input type="checkbox"/> hypoglycemic | <input type="checkbox"/> asthma | <input type="checkbox"/> communicable diseases |

Other (specify): _____

With regard to your feet, check if you have (or have had) any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> broken bones (or ankle) | <input type="checkbox"/> tender spots | <input type="checkbox"/> tendon problems |
| <input type="checkbox"/> sprains | <input type="checkbox"/> bunions | <input type="checkbox"/> hammer toes |
| <input type="checkbox"/> cuts (or scars) | <input type="checkbox"/> ingrown toenails | <input type="checkbox"/> skin problems |

Other (specify): _____

Check if you have (or have had) problems with the following systems:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Endocrine | <input type="checkbox"/> Immune & Lymphatic | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Urinary | <input type="checkbox"/> Musculo-skeletal | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Digestive | <input type="checkbox"/> Reproductive |

Is there anything else about your health you would like to disclose? _____

What is your reason for seeking a reflexology treatment? _____



You Need to Know That:

1. I am not a doctor.
2. I do not practice medicine.
3. I do not diagnose or treat for a specific illness.
4. I do not prescribe or adjust medication.
5. Reflexology is not a substitute for medical treatment, but is a complement to most types of therapy.

What Is Reflexology?

Reflexology is an ancient, manual technique based upon the concept that the entire body is reflected as a system of reflexes on the feet (hands and ears as well). By pressing on these reflexes with fingers, one is able to bring about relaxation and balance in the body, and also assist in overall stress reduction and enhancement of well-being.

What Does Reflexology Do?

Studies show that:

1. Reflexology promotes balance and normalization of the body naturally.
2. Reflexology reduces stress and brings about relaxation.
3. Reflexology stimulates circulation and the delivery of oxygen and nutrients to the cells.

By signing this form, I certify that the above information is correct to the best of my knowledge. I give my consent to a Reflexology session. I understand that I may discontinue a session or sessions at any time for any reason, and if I feel at all uncomfortable I should tell my practitioner.

If I have been diagnosed by a licensed health professional as having any disease, injury or other physical or mental condition, I understand that I should inform the person who made that diagnosis about the reflexology session I am receiving. If I have any communicable condition or condition that may contaminate the therapy area, I may be refused service until such time as that condition is certified as cleared.

I understand that this reflexology session should not be construed as a substitute for medical treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment. I fully understand that the therapist conducting this session is not an allopathic doctor, psychologist, or psychiatrist and does not portray himself/herself to be. I agree to keep the practitioner updated as to any changes in my medical profile prior to any future sessions and understand that there shall be no liability on the therapist's part nor on the part of Therapeutic Healing and Wellness Centre should I fail to do so.

I understand that I will be liable for payment of the scheduled appointment. The therapist also reserves the right to refuse service to anyone for any reason. By signing below I acknowledge that I have read and understand all parts of this consent/intake form and that I have had the opportunity to ask any questions with regard to any services or therapies offered. All client information is confidential.

Print Name _____

Signature _____

Today's Date _____