Confidential
Reflexology Health History Record

Name:_____
Phone: _____
Address:_____
Postal Code:_____
Email address_____
Occupation: _____
Work Phone Number: _____
Doctor: _____
Dr's Phone Number: _____
Date of last Dr. visit: _____

Sex: M F
Date of Birth ___ _____ ____
day month year

Women only:
Are you pregnant? Yes/No
Have you ever been pregnant? Yes No

Men only:
Do you have/had prostrate problems?
Yes No

General Health History

Are you in good Health? Yes No

Are you diabetic? Yes No

Do you have hypoglycemia? Yes No

What are you doing for your health?
_____
_____

Other therapies? (Please Identify)
_____
_____

Have you ever had surgery?
When? _____

Have you ever had an accident/serious illness?
When? _____

Do you sleep well? Yes No
Do you have headaches? Yes No
How is your blood pressure? Low Med. High
How is your stress level? Low Med. High
Do you suffer from anxiety/worry? Yes No
Do you have joint problems? Yes No
Do you have allergies/sinus conditions? Yes No
If yes, describe: _____
Please list medications including vitamins and supplements:
(list medications on back of page if necessary)
_____
_____
_____
_____
_____
What are your goals/expectations for this session?
_____
_____

Please indicate your consumption level of the following: L (low) M (medium) H (high) N (none)

Salt L M H N	Tobacco L M H N	Water _____
Sugar L M H N	Alcohol L M H N	(# of glasses per day)
Caffeine L M H N	Exercise L M H N	

Consent to receive treatment

I the undersigned, consent to reflexology treatment and understand that sessions are for the purpose of stress reduction, relaxation and wellness. I may stop the session at any time, either during the assessment or the treatment.
Reflexologists do not diagnose, prescribe medication for medical or psychological conditions, or treat for specific conditions.

Signature : _____ Date: _____

Reflexology Health Record

Do you have any concerns with the following areas:

ENDOCRINE SYSTEM: Yes _____ No _____
(e.g. diabetes, hypoglycemia, menopausal problems, hyper/hypo thyroidism, prostate)
Specify: _____

URINARY SYSTEM: Yes _____ No _____
(e.g. kidney disease, bladder problems)
Specify: _____

CARDIOVASCULAR SYSTEM: Yes _____ No _____
(e.g. High/Low blood pressure, heart disease, phlebitis, varicose veins, circulation problems, anemia, etc.)
Specify: _____

IMMUNE AND LYMPHATIC SYSTEM: Yes _____ No _____
(e.g. arthritis, chronic fatigue, environmental illness, HIV/AIDS, allergies, TB, cancer, etc.)
Specify: _____

MUSCULOSKELETAL SYSTEM: Yes _____ No _____
(e.g. osteoporosis, fibromyalgia, bursitis, gout, back pain, scoliosis, foot or hand problems)
Specify: _____

RESPIRATORY SYSTEM: Yes _____ No _____
(e.g. asthma, emphysema, bronchitis, sinitus, earaches
Specifiy: _____

NERVOUS SYSTEM: Yes _____ No _____
(e.g. vision, hearing loss/problems, loss of sensation, nerve pain/damage, mental or emotional Problems, MS)
Specify: _____

REPRODUCTIVE SYSTEM: Yes _____ No _____
(e.g. PMS, dysmenorrhea, endometriosis, prostate problems, etc.)
Specify: _____

DIGESTIVE SYSTEM: Yes _____ No _____
(e.g. liver, gallbladder, difficult digestion, prolonged constipation, diarrhea, Chrohn's Disease, colitis, diverticulitis, ulcer etc.)
Specify: _____

INTEGUMENTARY (SKIN) SYSTEM: Yes _____ No _____
(e.g. Psoriasis, eczema, warts, etc.)
Specify: _____