

# REFLEXOLOGY HEALTH RECORD FORM

Date of Session: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Please answer these questions as accurately as possible and to the best of your knowledge. We subscribe to Patient/Practitioner confidentiality meaning that the information given here or during a session will remain completely confidential.**

1) Are you undergoing any other therapies? If so Specify.

2) When was the last visit to your doctor? For what reason?

3) List past injuries and serious illnesses. When?

4) Are you taking any medications, vitamins, dietary supplements or over the counter medication?

5) Please circle your consumption level of the following:

Salt	<b>None</b>	<b>Light</b>	<b>Moderate</b>	<b>Heavy</b>
Sugar	<b>None</b>	<b>Light</b>	<b>Moderate</b>	<b>Heavy</b>
Caffeine	<b>None</b>	<b>Light</b>	<b>Moderate</b>	<b>Heavy</b>
Tobacco	<b>None</b>	<b>Light</b>	<b>Moderate</b>	<b>Heavy</b>
Alcohol	<b>None</b>	<b>Light</b>	<b>Moderate</b>	<b>Heavy</b>
Exercise	<b>None</b>	<b>Light</b>	<b>Moderate</b>	<b>Heavy</b>
Water	<b>None</b>	<b>Light</b>	<b>Moderate</b>	<b>Heavy</b>

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Please mark all of the conditions below that you have now (X) or have in the past (P).

## Endocrine System:

- \_\_\_ Menopausal Problems
- \_\_\_ Hypothyroidism
- \_\_\_ Hyperthyroidism
- \_\_\_ Diabetes
- \_\_\_ Hypoglycemia
- \_\_\_ Other \_\_\_\_\_

## Digestive System:

- \_\_\_ Ulcers
- \_\_\_ Irritable Bowel Syndrome
- \_\_\_ Colitis
- \_\_\_ Diarrhea
- \_\_\_ Constipation
- \_\_\_ Other \_\_\_\_\_

## Cardiovascular System:

- \_\_\_ Heart Disease
- \_\_\_ Varicose Veins
- \_\_\_ High or Low Blood Pressure
- \_\_\_ Anemia
- \_\_\_ Circulatory Problems (cold hands or feet)
- \_\_\_ Other \_\_\_\_\_

## Respiratory System:

- \_\_\_ Asthma
- \_\_\_ Emphysema
- \_\_\_ Bronchitis
- Shortness of breath
- \_\_\_ Other \_\_\_\_\_

## Integumentary (Skin)

- \_\_\_ Warts
- \_\_\_ Rashes
- \_\_\_ Psoriasis
- \_\_\_ Eczema
  
- \_\_\_ Other \_\_\_\_\_

## Reproductive System:

- \_\_\_ PMS (cramps, bloating, mood)
- \_\_\_ Endometriosis
- \_\_\_ Problems Menstruating
- \_\_\_ Prostate Problems
- \_\_\_ Difficulty with pregnancies
- \_\_\_ Sexual Transmitted Diseases
- \_\_\_ Other \_\_\_\_\_

## Immune/Lymphatic System:

- \_\_\_ Chronic Fatigue
- \_\_\_ Arthritis
- \_\_\_ Aids/HIV
- \_\_\_ Cancer
- \_\_\_ Allergies
- \_\_\_ Other \_\_\_\_\_

## Musculoskeletal System:

- \_\_\_ Osteoporosis
- \_\_\_ Muscle Spasms or Joint Pain
- \_\_\_ Back and Neck Pain
- \_\_\_ Hand or Foot Pain
- \_\_\_ Fibromyalgia
- \_\_\_ Bursitis
- \_\_\_ Broken Bones
- \_\_\_ Other \_\_\_\_\_

## Nervous System:

- \_\_\_ Depression
- \_\_\_ Vision/Hearing Loss
- \_\_\_ Nerve Damage resulting in loss of sensation.
- \_\_\_ Mental and Emotional Problems

## Women Only:

- Are you pregnant? YES/NO
- If so, when is the due date?
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**Are you currently experiencing pain? If so where?**

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## **Waiver of Responsibility**

I understand that the Reflexology I receive is for the reduction of stress, relaxation, pain relief and to increase circulation. If I experience any discomfort, I will immediately inform the Reflexologist so that the pressure can be adjusted to my comfort level. I understand that the Reflexologist does not diagnose illness or prescribe any medical treatments. I acknowledge that Reflexology is not a substitute for medical examination or diagnosis and that I should see a health care provider for those services. Because Reflexology should not be performed under certain circumstances, I agree to keep the Reflexology practitioner updated as to any changes in my health profile, and release the Reflexologist from any liability if I fail to do so.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_