Reflexology Health Record

Name:	**DOB:**
Street Address:	**Home Phone:**
Town:	**Cell Phone:**
Postal Code:	**Email:**

Date of last medical visit:			Findings (Medical):
Check YES or NO for following questions:			***If YES, specify: What / When.***
Have you had any accidents?	NO	YES	
Do you have any serious illness?	NO	YES	
Have you been hospitalized recently?	NO	YES	
Have you had any broken bones?	NO	YES	
Have you have any surgery**?	NO	YES	
Are you any medication?	NO	YES	
Do you have any heart problems?	NO	YES	
Do you have a pacemaker?	NO	YES	
Is your blood pressure normal?	NO	YES	
Do you have circulation problems?	NO	YES	
Are you pregnant?	NO	YES	
Family history of cancer?	NO	YES	
Do you have diabetes?	NO	YES	
Do you have epilepsy?	NO	YES	
Do you wear any prostheses? (hearing aids, limbs etc.)	NO	YES	
Do you smoke/have allergies?	NO	YES	
Are you taking other therapies?	NO	YES	
Have you had Reflexology before?	NO	YES	

Who referred you to us?____________________________ **What is your occupation?**____________________
Who is your doctor?______________________________ **Doctor's Telephone #:** ______________________
Present health concerns:____

*****Reflexology increases bloodflow therefore we cannot safely work on you if you have had <u>any surgery</u> or <u>medical procedures</u> in the past four (4) weeks. Please book you appointment accordingly.***

CONSENT FOR REFLEXOLOGY SESSION: I understand and accept that the sessions are of therapeutic value only and fully accept responsibilty for the same.

Signature:____ **Date:** ________________________________