Reflexology Health Record

Note:
This form to be completed by client first then reflexologist for initial session.

ate: _____

Client: _____

Tel. (Res.) _____ (Bus.) _____

Address: _____ Date of Birth: _____

City & Province: _____ Postal Code: _____

Doctor: _____ Doctor Tel.: _____

Doctor Address: _____

1. What is your occupation? _____
2. Are you in good health? Yes ☐ No ☐
3. Are you undergoing other therapies? Yes ☐ No ☐
   List: _____
4. What else are you doing for your health? _____
   _____
5. What are your goals/expectations for this session?
   _____
6. When did you last visit your doctor? _____
   Reason: _____
7. List past surgeries and time of same: _____
   _____
   _____
8. List past injuries and time of same: _____
   _____
   _____
9. Are you taking medications? (Please include any vitamins or dietary supplements.) Yes ☐ No ☐
   Reason for taking: _____
   _____
10. Do you sleep well? Yes ☐ No ☐
    Explain: _____
11. Do you suffer from anxiety or worry? Yes ☐ No ☐
    Explain: _____
12. Is your blood pressure:
    Normal ☐ High ☐ Low ☐ Stable ☐ Erratic ☐
13. Are you pregnant? Yes ☐ No ☐
    If yes, which trimester? 1 ☐ 2 ☐ 3 ☐
14. Have you had other pregnancies? Yes ☐ No ☐
15. Do you have allergies/sinus conditions? Yes ☐ No ☐
    List: _____
16. If you have varicose veins? Yes ☐ No ☐
17. Do you wear protheses (e.g. glasses, contacts, glass eye, artificial joints/limbs, metal plates, pins or wires, dentures, hearing aid?) Yes ☐ No ☐
    If yes, please list: _____
18. Is there anything else about your health you wish to discuss?
    _____
19. Are you presently experiencing any of the following?
    Sunburn ☐ Inflammation ☐ Pain ☐ Headache ☐
    Skin rash ☐ Cold/flu ☐ Cuts, bruises, burns ☐
    Decreased range of motion ☐ Other ☐
20. Please indicate your consumption level of the following:

	NONE	LIGHT	MODERATE	HEAVY
Salt	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Water	☐	☐	☐	☐

CONSENT TO RECEIVE TREATMENT

I, the undersigned, consent to reflexology treatment and understand that sessions are for the purpose of stress reduction and relaxation.

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

Continued on reverse ...

REFLEXOLOGY HEALTH RECORD

Do you have problems with any of the following systems?

ENDOCRINE SYSTEM:
(E.g. diabetes, hypoglycemia, menopausal problems, hypothyroidism, hyperthyroidism) **Y N**
Specify:_____

URINARY SYSTEM: **Y N**
(E.g. kidney disease, urinary problems)
Specify:_____

CARDIOVASCULAR: **Y N**
(E.g. High/low blood pressure, heart disease, phlebitis, varicose veins, circulation problems, anemia, etc.)
Specify:_____

IMMUNE & LYMPHATIC: **Y N**
(E.g. arthritis, chronic fatigue, environmental illness, HIV/AIDS, allergies, etc.)
Specify:_____

MUSCULOSKELETAL: **Y N**
(E.g. osteoporosis; fibromyalgia; bursitis; gout; back pain; scoliosis; foot, arm, or hand problems)
Specify:_____

RESPIRATORY: **Y N**
(E.g. asthma, emphysema, etc.)
Specify:_____

NERVOUS: **Y N**
(E.g. vision, hearing loss/problems; loss of sensation; nerve pain/damage; mental or emotional problems, MS)
Specify:_____

REPRODUCTIVE: **Y N**
(E.g. PMS, dysmenorrhoea, endometriosis, prostate problems, etc.)
Specify:_____

DIGESTIVE: **Y N**
(E.g. prolonged constipation, diarrhoea, Crohn's Disease, colitis, diverticulitis, ulcer, etc.)
Specify:_____

INTEGUMENTARY (SKIN): **Y N**
(Psoriasis, eczema, warts, etc.)
Specify:_____

OTHER:

Tuberculosis	**Y N**
Hepatitis	**Y N**
Herpes	**Y N**
Cancer	**Y N**
HIV/AIDS	**Y N**

If client is experiencing pain, use the reminder phrase **OL DR FICARA** when questioning the client to determine the following:

Onset?	**F**requency?
Location?	**I**ntensity?
Character (dull, sharp, etc.)?	
Duration?	**A**ssociated symptoms?
Radiation?	**R**elieving factors?
Aggravating factors?	

NOTES