



Date _____

Name _____	Phone _____
Address _____	Email _____
City _____ State _____ Zip _____	Birth Date _____
Occupation _____	Referred By _____
Emergency Contact _____	Phone _____

The following information will be used to help plan safe and effective Reflexology sessions. Please answer these questions to the best of your ability.

How would you rate your current state of health: Excellent Good Fair Poor

Are you currently under a doctor's care? If so explain: _____

Please circle any health issue that applies to you in the list below.

Frequent Headaches	Rashes	Parkinson's Disease
Joint stiffness or swelling	Acne	Alzheimer's Disease
Arthritis	Athlete's foot or fungus	Recent Surgery
Osteoporosis	Open Wounds or cuts	Edema (Swelling, water retention)
Bursitis	Diabetes I or II	Lymphedema
Tendonitis	Heart Disease	High Blood Pressure - Treated
Scoliosis	Fibromyalgia	Asthma
TMJ or mouth pain	Multiple Sclerosis	Cancer
Back pain	Muscular Dystrophy	Pregnancy _____ Months

Are you taking any medications? If so, what and when was it last taken? _____

List previous major illnesses, accidents, surgeries or broken bones: _____

List other therapies besides conventional medicine or chiropractics in which you are currently participating: _____

Are you experiencing any problems with your feet/ears? If so, explain: _____

Where is tension most evident in your body? _____

I receive how many of hours of sleep each night... _____

Have you experienced reflexology before? If so, when? _____

Do you have any specific goals for our sessions? _____

Please elaborate on any of the information above and comment on how you are feeling today, thank you.

I am feeling: _____



Happy



Great!



Sad



Anxious



Afraid



Moody



Angry



Tired
