



REFLEXOLOGY HEALTH RECORD

THIS FORM IS TO BE COMPLETED BY THE CLIENT FIRST THEN BY PRACTITIONER FOR INITIAL SESSION

Client					Date of Birth				
Telephone	Home				Business			Ext	
Email Address									
Street #			Street Name						
City				Province				Postal Code	
Doctor's Name					Telephone				
Doctor's Address									

1. What is your occupation? _____
2. Are you in good health? Yes No Explain: _____
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
Reasons 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? 1st 2nd 3rd

14. Have you had other pregnancies? Yes No

15. Do you have allergies/sinus conditions? Yes No

List: _____

16. Do you have varicose veins? Yes No

17. Do you wear prostheses (e.g. glasses, contacts, glass eye, artificial joints/limbs, metal plates, pins, or wires, dentures, hearing aids?) Yes No Circle which one

18. Is there anything else about your health you wish to discuss? Yes No

Explain: _____

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 by placing an X in the appropriate column.

	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 anytime, either during the assessment or the treatment.

Reflexologists do not diagnose, prescribe medication for medical or psychological conditions, nor treat for specific conditions.

Signature: _____ Date: _____

Do you have problems with any of the following systems?

Endocrine System	<i>(diabetes, hypoglycemia, menopausal problems, hypothyroidism)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Urinary System	<i>(kidney disease, urinary problems)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Cardiovascular	<i>(high/low blood pressure, heart disease, phlebitis, varicose veins, circulation problems, anemia, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Immune & Lymphatic	<i>(arthritis, chronic fatigue, environmental illness, HIV/AIDS, allergies, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Musculoskeletal	<i>(osteoporosis, fibromyalgia, bursitis, gout, back pain, scoliosis foot, arm or hand problems)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Respiratory	<i>(asthmas, emphysema, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Nervous System	<i>(vision, hearing loss/problems, loss of sensation, nerve pain/damage, mental or emotional problems, MS)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Reproductive	<i>(PMS, dysmenorrhea, endometriosis, prostate problems, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Digestive	<i>(prolonged constipation, diarrhea, Crohn's Disease, Colitis, diverticulitis, ulcer, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Integumentary (Skin)	<i>(Psoriasis, eczema, warts, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			

Other

Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Aids	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

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

Onset?	Duration?	Frequency?	Character (dull, sharp, etc.)?	Relieving Factors?
Location?	Radiation?	Intensity?	Aggravating Factors?	Associated Symptoms?

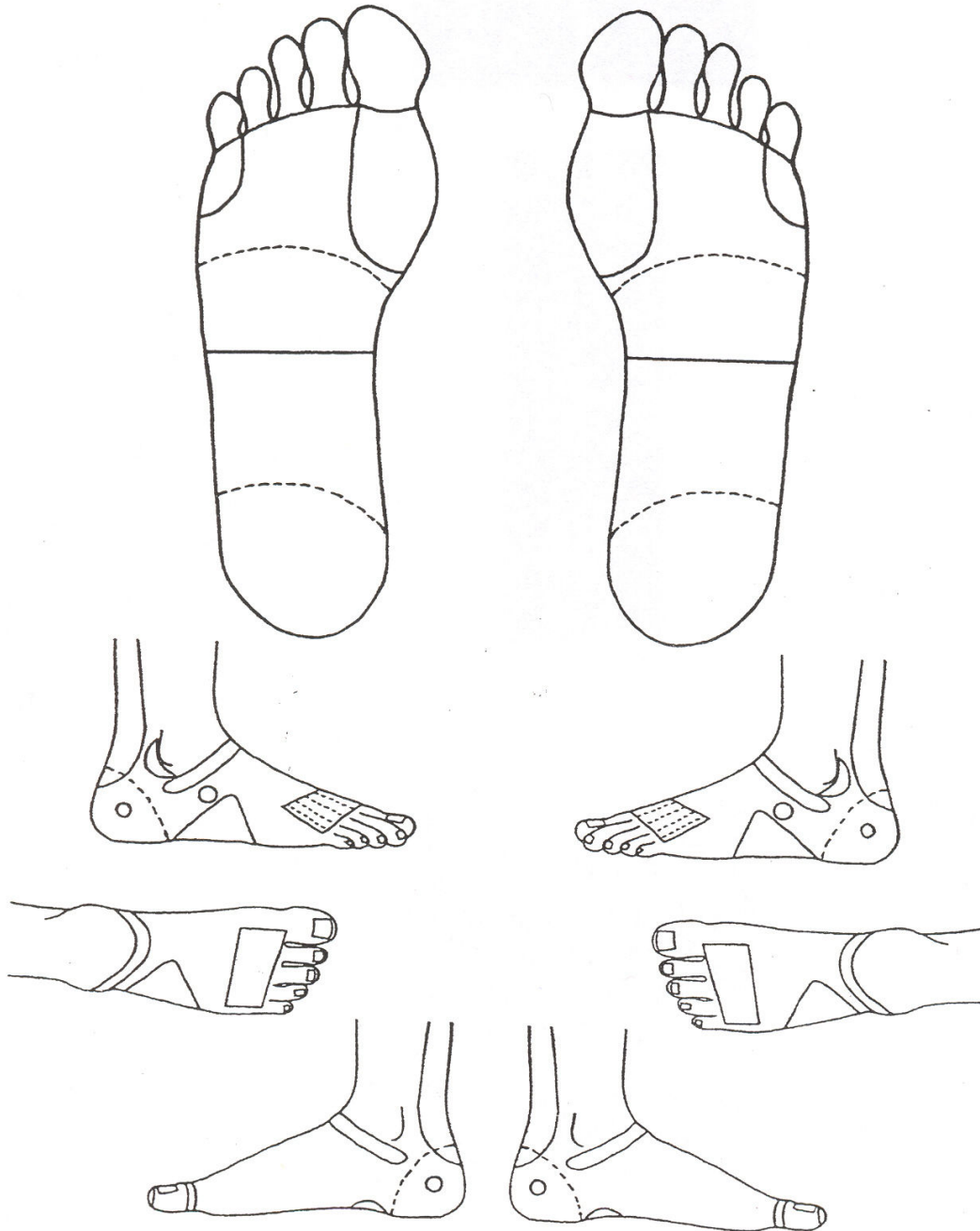
REFLEXOLOGY INITIAL TREATMENT RECORD

NOTE: A GLOSSARY OF SYMBOLS MUST ACCOMPANY THIS PAGE FOR REFERENCE

Client: _____

Date of Initial Session: _____

Client Signature: _____



All questions to be completed for each session-use 'Notes' page if needed

Client Name and Client Signature: _____

Date: _____

Felt Last Treatment

Felt Since Treatment

Feels Today

Observations of Client

Foot Observations

Right

Left

Findings During Treatment

Action Taken

Results

Clients Comments

Final Observations

Treatment Notes –

