Reflexology Patient Form

Personal Information

Please fill out this form and bring it with you to your appointment.

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Health Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use:

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

Have you had any recent injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

Please rate the following on a scale of 1(bad) – 5(excellent)

	1	2	3	4	5
Quality of Sleep	○	○	○	○	○
Energy Levels	○	○	○	○	○
Stress Levels	○	○	○	○	○
Quality of Nutrition	○	○	○	○	○
Exercise Habits	○	○	○	○	○

Treatment Information

Have you had Reflexology before? ☐ yes ☐ no

Why are you seeking Reflexology today?

_____

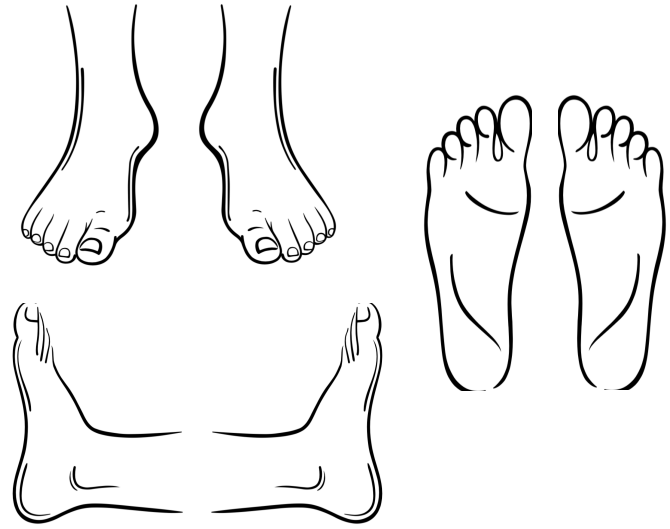
_____

What are your goals for this session?

_____

_____

The section below to be completed by reflexologist.



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my Reflexologist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Reflexologist Signature _____ *Date* _____