

Reflexology Health Record

Name: _____ Date: _____

Address: _____ Pcode : _____

Phone (H): _____ Phone (W): _____ Phone (C): _____

Occupation: _____ Birthdate: _____

Doctor: _____ Location: _____

How did you hear about reflexology at Wascana Remedial Massage Centre? _____

Is this your first reflexology treatment? YES NO

What other therapies have you tried? _____

What are your goals / expectations for this session? _____

Is there a specific condition that you are concerned with? _____

List past surgeries and dates of: _____

List past injuries and dates of: _____

Are you taking any medication? _____

List medication & condition related: _____

Are you taking any herbal supplements / vitamins? _____

Do you sleep well? YES NO If no, please explain: _____

Do you suffer from anxiety or excessive stress? YES NO If yes, please explain: _____

Are you presently experiencing any of the following? (please circle)

SUNBURN	PAIN	HEADACHE	COLD / FLU	ALLERGIES
DECREASED RANGE OF MOTION		PLANTAR WARTS		INFLAMMATION

Please circle the consumption level of the following:

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

Is there anything else you would like to discuss about your health? _____

CONSENT TO RECEIVE TREATMENT

I, the undersigned, consent to reflexology treatment and understand that the 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