SOLE Heeling

Reflexology Health Record

Name: _____ Date: _____

Address: _____ Home #: _____

Town / City: _____ Work #: _____

Prov./State: _____ PC/Zip: _____ Birth Date: _____

Last Medical Visit: _____ Findings (Medical): _____
Have you had any accidents? Yes__ No___ What/When? _____
Do you have any serious illness? Yes__ No___ What/ When? _____
Have you been hospitalized recently? Yes__ No___ What/ When? _____
Have you had any broken bones? Yes__ No___ What/ When? _____
Have you had any surgery? Yes__ No___ What/ When? _____
Are you on medication? Yes__ No___ What/ When? _____
Do you have any heart problems? Yes__ No___ What/ When? _____
Do you have a pacemaker? Yes__ No___ What/ When? _____
How is your blood pressure? Normal __ Not Normal__ Why? _____
Do you have any circulatory problems? Yes__ No___ What? _____
Are you pregnant? Yes__ No___ Trimester? _____
Any history of cancer? Yes__ No___ What/ When? _____
Do you have diabetes? Yes__ No___ What/ When? _____
Do you have epilepsy? Yes__ No___ What/ When? _____
Do you wear any prostheses? Yes__ No___ What/ When? _____
Do you smoke / have allergies? Yes__ No___ What/ When? _____
Are you taking other therapies? Yes__ No___ What? _____
Have you had reflexology before? Yes__ No___ Who/ When? _____
Who is your doctor? _____ DR. Tel. # _____
Present Problems: _____
_____
Who referred you to me? _____

Consent for Reflexology Session:

I understand and accept that the sessions received are of therapeutic value only and fully accept responsibility for the same.

Signature: _____ Date: _____