REFLEXOLOGY
Training Academy of Canada

Date: _____

Name: _____ Birth Date: _____

Address: _____ Home Phone: _____

Postal Code: _____ Email: _____

Doctor's Name: _____ Address: _____ Phone: _____

Is this your first reflexology session? Yes / No How did you hear about us? _____

What is your primary goal for today's session? _____

Are you currently under a doctor's care? If yes, please explain: _____

Are you taking medication? Yes / No if so, for what? _____

_____

Do you have allergies? Yes / No if yes, to what? _____

Where is the most evident spot of tension in your body? (i.e. neck, jaw, back, hips) _____

Are you pregnant or trying to get pregnant? Yes / No If pregnant, how far along? _____

Are you experiencing menopause? Yes / No

Are you undergoing other therapies? Yes / No If yes, what type? _____

Circle if applicable: Fever, Infection, Cold/Flu, Inflammation, if so where? _____

Are you in pain today? Yes / No If yes, circle level: 1 2 3 4 5 6 7 8 9 10 (10 being very high)

If yes, where are you experiencing this pain? _____

_____

Do you feel you eat a healthy diet? Circle level: 1 2 3 4 5 (5 being very healthy)

Do you exercise? Circle level: 1 2 3 4 5 (5 being very healthy)

Current Stress level: Circle level: 1 2 3 4 5 6 7 8 9 10 (10 being very high)

Is relaxation challenging for you Yes / No Comments: _____

How many hours a night do you sleep? 1 2 3 4 5 6 7 8 9 10 More

Please list any major illnesses, fractures, surgeries, hospitalization and approximate age they occurred.

_____

_____

Please mark '**R**' for right foot and '**L**' for left foot if these conditions apply:

Plantar fasciitis _____ Gout _____ Neuropathy _____ Plantar warts _____ Bunion _____

Morton's Neuroma _____ Bruising _____ Athlete's foot _____Bone spur _____ Orthotics _____

Other: _____

Please mark '**N**' for chronic conditions you now have and '**P**' for past conditions:

| | | |
|---|---|---|
| ___ Heart problem | ___ Numbness | ___ Allergies/hay fever |
| ___ Blood pressure | ___ Teeth grinding | ___ Sinusitis |
| ___ Embolism (blocked artery) | ___ Menstrual issues | ___ Respiratory issues |
| ___ Diabetes | ___ Ovarian issues | ___ Dyslexia |
| ___ Kidney ailments | ___ Osteoporosis | ___ Headaches |
| ___ Bladder ailments | ___ Arthritis | ___ Eye strain |
| ___ Ear infections | ___ Bursitis/tendonitis | ___ Chronic pain |
| ___ Constipation | ___ Joint disorders | ___ Skin disorders |
| ___ Irritable bowel syndrome | ___ Sleep disorders | ___ Eczema |
| ___ Sciatica | ___ Addiction | ___ Phlebitis |
| ___ Neck Injury | ___ Asthma | ___ Varicose veins |
| ___ Spinal injury | ___ Stress | |

The above information is accurate and true to the best of my knowledge. I understand that no diagnosis is implied or offered. I understand these records will be maintained in a confidential manner, no information shall be released without my written authorization, unless compelled by law.

I voluntarily consent to a reflexology treatment. I fully understand that reflexology is not meant to substitute as treatment for any medical condition; and I render the reflexologist harmless with respect to any effects experienced as a result of this treatment.

_____ _____

Print Name Signature