Reflexology Intake Form

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Confirmation: E-mail / Phone / Text

DOB (D/M/Y): \_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ How do you identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AHC # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information**  Please Mark areas of discomfort into Are you taking any medications or supplements? feet and hands:

Yes / No

If yes, please let us know what?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies or sinus conditions?

Yes / No

Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from anxiety and/or stress?

Yes / No Are you currently Pregnant?

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

Have you had any recent surgeries or injuries? If yes, how far along? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you comfortable laying on your back?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have any medical conditions not listed

 Above? Yes / No

☐ Chronic Fatigue ☐ Cancer Are you in overall health? Yes / No

☐ Heart Disease ☐ Diabetes If No, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Varicose Veins ☐ Headaches

☐ Circulation Problems ☐ Migraines ☐ Digestive Issues

☐ Stroke / CVA ☐ Arthritis ☐ High / Low Blood Pressure

☐ Thrombosis / DVT ☐ Botox / Fillers ☐ Depression

☐ Blood Clots

Please rate the following on a scale 1 (good) 10 (bad): Have you received Reflexology treatments before:

 Yes / No When?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quality of sleep: \_\_\_\_\_\_

Energy levels: \_\_\_\_\_\_ How well do you sleep?

Stress levels: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise habits: \_\_\_\_\_\_

Quality of nutrition: \_\_\_\_\_\_ Do you have any warts or toe fungus? Yes / No

Swelling into hands and feet: \_\_\_\_\_\_ If yes, have you received treatment?

Tingling or numbness: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cold hands and feet: \_\_\_\_\_\_

**Informed consent**

I have completed this health form to the best of my knowledge and have disclosed all medications, vitamins and minerals that I am currently taking. I agree to keep the Reflexologist updated to any changes in my medical history, including mental, emotional and physical health, and further understand that the massage therapist/ reflexologist is not liable.

I understand that the professional treatment I receive is for the purpose of improving, restoring, and/or maintaining my personal health. I Further understand that Reflexologists do not diagnose illness or disease, prescribe medication or make spinal adjustments.

I understand there is potential for mild side effects with massage therapy, including but not limited to: Muscle soreness (lasting 24-48 hours), lightheadedness, slight inflammation, increased need for urination and nasal congestion

I understand that massage therapy and reflexology is not a substitute for medical examination, diagnosis, or treatment and recommended that I am working in conjunction with my primary caregiver for any condition that I may have. This information will be kept confidential unless required by law or after I have given consent to release information

**Client Signature: Date:**

**Parent/Guardian Signature: Date:**

**Therapist Signature: Date:**

**CANCELLATION POLICY**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand by initialling below I agree and recognize that a minimum of 24 hours notice is required to cancel appointments. Missed appointments without notice will be subject to a missed appointment fee equal to that of your scheduled appointment time. An appointment is considered missed if you arrive more then 15 minutes late. In addition, please understand that most insurance companies will not reimburse for missed appointments  **Initial here \_\_\_\_\_\_\_\_\_\_\_\_**