REFLEXOLOGY CLIENT INTAKE FORM

PERSONAL INFORMATION

Name: _____

Address: _____

Cell Phone: _____

HEALTH INFORMATION

Are you taking any medications? ☐ Yes ☐ No

-If yes, please list the names and reasons for the medications:

Are you currently pregnant? ☐ Yes ☐ No -If yes, how far along? _____

-Any high risk factors? _____

Do you have any allergies or sensitivities? ☐ Yes ☐ No

-If yes, please specify:

Have you had any recent injuries? ☐ Yes ☐ No

-If yes, please specify: _____

Please indicate any of the following that apply to you:

☐ Cancer

☐ Headache/migraines

☐ Arthritis

☐ Diabetes

☐ Joint replacement(s)

☐ High/low blood pressure

☐ Neuropathy

☐ Fibromyalgia

☐ Stroke

☐Heart attack

☐ Kidney dysfunction

☐ Blood clots

☐ Numbness

☐ Sprains/strains

☐ Other:

_____

-Explain any conditions you have indicated above:

Rate the following on a scale form 1 - 5:

Quality of sleep:

Quality of nutrition:

Energy levels:

Exercise habits:

Stress levels:

Poor - □ 1 □ 2 □ 3 □ 4 □ 5 - Excellent

Poor - □ 1 □ 2 □ 3 □ 4 □ 5 - Excellent

Poor - □ 1 □ 2 □ 3 □ 4 □ 5 - Excellent

Poor - □ 1 □ 2 □ 3 □ 4 □ 5 - Excellent

Poor - □ 1 □ 2 □ 3 □ 4 □ 5 - Excellent

TREATMENT INFORMATION

Have you had reflexology before? □ Yes □ No

Please describe any areas where you're experiencing discomfort:

ACKNOWLEDGMENT

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 : _____

Print name: _____