



Facial Reflexology (Dien Chan) Questionnaire

Please complete this form so that I may obtain a clear indication of your current condition.

Name: _____ Your age? _____

Street address: _____ City: _____

Postal Code: _____ Email: _____

Cell phone no: _____ Doctor's name: _____

What is your occupation? _____

Where did you hear about me? (e.g. social media - which one? Google search? Flyer? Referral?)

Facial reflexology should be avoided when these conditions are present. Do you have:

- | | | |
|---|------------------------------|-----------------------------|
| Infectious skin and scalp disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any infectious disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High temperature, illness, or fever? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Broken bones/fractures in your face? Neck? Where? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do you have any of these conditions? Do you have:

- | | | |
|---|------------------------------|-----------------------------|
| Cuts/abrasions on your face or neck? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rosacea? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lupus? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Acne? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hormone imbalance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold sores? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neck strains/sprains? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Face, Jaw and/or Neck surgery(ies)? Explain: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any neurological issues? Explain: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been injected with Botox? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, where? _____ Yes No

When? _____

Is there anything else I should know about your health? _____

Consent to Receive Treatment:

I, the undersigned, consent to a facial reflexology treatment and understand that sessions are for stress reduction, relaxation, and facial rejuvenation. I may stop the session at any time, either during the assessment or the treatment. Reflexology Therapists do not diagnose, prescribe medication for medical or psychological conditions, nor treat for specific conditions. I understand that the treatment should not be construed as a substitute for medical examination, diagnosis or treatment and that I should consult a physician or other qualified medical specialist for mental or physical ailments that I am aware of.

Your name (please print): _____

Your signature: _____

Today's date: _____