Your Health Record

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

Name: ____ **Date of birth:** _______________________

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?

____

1. What are your goals/expectations for this session? ____

   ____

2. How would you describe your general health? ____

   ____

3. How are you currently feeling? ____

   ____

4. Are you currently doing any of the following?

   Doing exercise: ❑ Yes ❑ No
   Doing any relaxation techniques: ❑ Yes ❑ No
   Seeing a Chiropractor/Podiatrist/Naturopath: ❑ Yes ❑ No
   Eating dairy products? ❑ Yes ❑ No
   Eating sugar? ❑ Yes ❑ No
   Eating carbohydrates (gluten)? ❑ Yes ❑ No
   Taking Vitamins/Minerals/Herbs: ❑ Yes ❑ No If ***yes***, please list them:
   ____

5. What else are you doing to remain healthy? ____

   ____

6. How is your spine? ____

7. Do you experience any pain or discomfort with your *feet*? ❑ Yes. If ***yes***, describe: ❑ No
   e.g., bunions, neuroma

   ____

8. Are you currently undergoing any therapies? ❑ Yes. If ***yes,*** please list them: ❑ No

   ____

9. When did you last visit your doctor (approx. date): ______________________

   The reason for your visit? ____

10. List what past surgeries you've had & when they occurred (approx. date): ______________________

    ____

    ____

11. List what past injuries you've had & when they occurred (approx. date): *e.g. falls, sprains, etc.*

    ____

    ____

12. Have you had any broken bones? ❑ Yes ❑ No If ***yes,*** which bones? ______________________

13. Are you taking any medications? ❑ Yes. If ***yes,*** please list them. Include vitamins & supplements:
    ❑ No

    ____

    ____

    ____

14. Do you have any heart or circulatory problems? ❑ Yes ❑ No

15. Do you have a pacemaker? ❑ Yes ❑ No

16. Do you smoke? ❑ Yes ❑ No If ***yes***, how much daily? __________________________________

17. Do you sleep well? ❑ Yes ❑ No. If ***no,*** please explain: __________________________________

    ____

18. Do you suffer from anxiety or worry? ❑ Yes. If ***yes***, please explain: ❑ No

____

____

19. How is your blood pressure? ❑ Normal ❑ High ❑ Low ❑ Stable ❑ Erratic

20. Are you pregnant? ❑ Yes. If ***yes*** which trimester are you in? ❑1st ❑2nd ❑3rd ❑ No

21. Have you had other pregnancies? ❑ Yes ❑ No

22. Do you have allergies or a sinus conditions? ❑ Yes. If ***yes***, please describe: ❑ No

____

____

23. Do you have varicose veins? ❑ Yes ❑ No

24. Do you wear a prosthesis? ❑ Yes. If ***yes***, please indicate: ❑ No

❑ Eye glasses ❑ Glass eye ❑ Contact lenses ❑ Dentures
❑ Artificial limb(s) ❑ Metal plate(s) ❑ Pins or Wires ❑ Hearing aid(s)

25. Are you currently experiencing any of the following? If ***yes,*** please indicate: ❑No

❑ Sunburn ❑ Inflammation ❑ Pain ❑ Headache
❑ Cuts ❑ Bruises ❑ Burns ❑ Rash
❑ Decreased range of motion
❑ Other: ____

26. Please indicate your consumption level of the following by placing an **X** in the appropriate column:

	None	**Light**	**Moderate**	**Heavy**
Alcohol				
Caffeine				
Exercise				
Salt				
Tobacco				
Water Consumption				

27. Is there anything else about your health you wish to discuss or let me know about?

❑ Yes. If ***yes***, please describe. Include any childhood illnesses or trauma:
❑ No

____

Your Standard Health Condition Record

Endocrine System	Yes	No	Diagnosed When?	What are your symptoms?
Diabetes				
Hyperthyroidism				
Hypoglycemia				
Hypothyroidism				
Menopausal Problems				
Urinary System	**Yes**	**No**	**Diagnosed When?**	**What are your symptoms?**
Kidney Disease				
Urinary Problems				
Cardiovascular System	**Yes**	**No**	**Diagnosed When?**	**What are your symptoms?**
Anemia				
Circulation Problems				
Heart Disease				
High / Low Blood Pressure				
Phlebitis				
Varicose Veins				

Immune & Lymphatic System	Yes	No	Diagnosed When?	What are your symptoms?
Allergies				
Arthritis				
Chronic Fatigue				
Environmental Illness				
HIV / AIDS				
Musculoskeletal System	**Yes**	**No**	**Diagnosed When?**	**What are your symptoms?**
Arm, Foot, Hand Problems				
Back Pain				
Fibromyalgia				
Gout				
Osteoporosis				
Scoliosis				
Respiratory System	**Yes**	**No**	**Diagnosed When?**	**What are your symptoms?**
Asthma				
Emphysema				

Reproductive System	Yes	No	Diagnosed When?	What are your symptoms?
Dysmenorrhoea				
Endometriosis				
PMS				
Prostrate Problems				
Digestive System	**Yes**	**No**	**Diagnosed When?**	**What are your symptoms?**
Colitis				
Constipation				
Crohn's Disease				
Diarrhea				
Diverticulitis				
Ulcers				
Integumentary or Skin Condition	**Yes**	**No**	**Diagnosed When?**	**What are your symptoms?**
Eczema				
Psoriasis				
Warts				

Please tell me if you have ever had any of these:

❑ AIDS/HIV ❑ Cancer ❑ Herpes ❑ Hepatitis ❑ Tuberculosis

❑ Other conditions: ____

____

Consent to Receive Treatment

I, the undersigned, consent to reflexology treatment and understand that sessions are for stress reduction and relaxation. 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: ____