

**REFLEXOLOGY CLIENT INTAKE FORM**

Disclaimer: Thank you for your interest in being a client of [CLINIC NAME]. Information collected about new clients is confidential and will be treated accordingly.

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| **PERSONAL INFORMATION** |

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Physician Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -**Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -**Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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:

Energy levels:

Stress levels:

Quality of nutrition:

Exercise habits:

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

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| **TREATMENT INFORMATION** |

**Have you had reflexology before?** [ ]  Yes[ ]  No

**Why are you seeking reflexology?**

**What are your goals for this session?**

**Please describe any areas where you’re experiencing discomfort**:

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| **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: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_