

**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.

|  |
| --- |
| **PERSONAL INFORMATION** |

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

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

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

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

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

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

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

|  |
| --- |
| **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

|  |
| --- |
| **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**:

|  |
| --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_