REFLEXOLOGY CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of .
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	☐ Neuropathy	☐ Numbness
☐ Headache/migraines	☐ Fibromyalgia	☐ Sprains/strains
☐ Arthritis	☐ Stroke	☐ Other:
☐ Diabetes	☐ Heart attack	_____
☐ Joint replacement(s)	☐ Kidney dysfunction	
☐ High/low blood pressure	☐ Blood clots	

-Explain any conditions you have indicated above:

Rate the following on a scale form 1 - 5:

Quality of sleep:	Poor - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Excellent
Energy levels:	Poor - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Excellent
Stress levels:	Poor - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Excellent
Quality of nutrition:	Poor - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Excellent
Exercise habits:	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: _____ Date: _____

Print name: _____