Reflexology Health Form

Name: _____

Telephone: (_____) _____ Date of Birth _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

How did you hear about me? _____

In Case of emergency: _____

Telephone: (_____) _____

General & Medical Information

Occupation: _____ Age: _____

Please take a moment to carefully read the following information and sign where indicated. If you have specific medical symptoms, reflexology may be contraindicated.

Have you ever experienced a professional reflexology session? _____ How recently? _____

If you answered yes to any of the following questions, please explain as clearly as possible to better assist the reflexologist.

Yes _____ No _____Do you frequently suffer from stress?
Yes _____ No _____ Do you have diabetes?
Yes _____ No _____ Do you experience frequent headaches?
Yes _____ No _____ Are you pregnant?
Yes _____ No _____ Do you suffer from arthritis?
Yes _____ No _____ Do you have high blood pressure?
Yes _____ No _____ Do you have allergies? If yes how severe? _____
Yes _____ No _____ Do you have any warts or contagious diseases?
Yes _____ No _____ Have you suffered from any injuries or been in an accident in the past 5 years?
Yes _____ No _____ Do you have any tension or soreness in a specific area?
Please specify _____
Yes _____ No_____ Do you have or have you ever had any soreness in your feet?
Please specify _____
Yes _____ No _____ Have you ever had heel spurs?
Yes _____ No _____Have you ever had plantar fasciitis?
Yes _____ No _____ Do you have any cardiac or circulatory problems?
Yes _____ No _____ Do you suffer from back pain?
Yes _____ No _____ Do you have any other medical condition or are you taking any medications I should know about?

I understand that the reflexology I receive is provided for the basic purpose of relaxation. If I experience any pain or discomfort during the session I will immediately inform the reflexologist so that the pressure may be adjusted to my level of comfort. I further understand that reflexology should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that the reflexologist is not qualified to diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because reflexology should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the reflexologist updated as to any changes in my medical profile and understand that there shall be no liability on the reflexologist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____
Date: _____

Reflexologist Signature: _____
Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Beneé Vinson to administer a reflexology session to my child or dependent, as they deem necessary.

Signature of Parent or Guardian:

_____

Date: _____