

Reflexology Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Health Information

Are you taking any medications? yes no
If yes, please list name and use: _____

Are you currently pregnant? yes no
If yes, how far along? _____
Any high risk factors? _____

Do you have any allergies or sensitivities? yes no
Please explain _____

Have you had any recent injuries? yes no
If yes, please list: _____

Please indicate any of the following that apply to you.

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Sprains or Strains |

Explain any conditions you have marked above:

Please rate the following on a scale of 1(bad) – 5(excellent)

Quality of Sleep	1	2	3	4	5
Energy Levels	1	2	3	4	5
Stress Levels	1	2	3	4	5
Quality of Nutrition	1	2	3	4	5
Exercise Habits	1	2	3	4	5

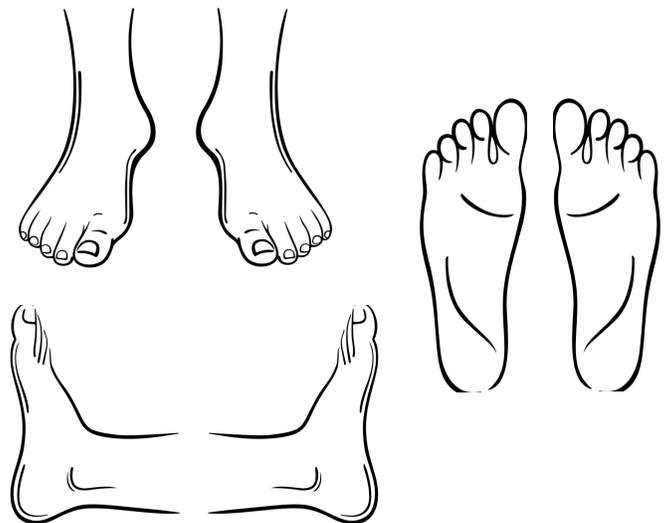
Treatment Information

Have you had Reflexology before? yes no

Why are you seeking Reflexology today?

What are your goals for this session?

Please circle any areas of discomfort:



*By signing below, you agree to the following.
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 _____

Reflexologist Signature _____ Date _____