Reflexology Intake:

Name:______________________________ DOB:_______________________________

Address: ____________________________ Phone:_____________________________

___________________________________ Email:_____________________________

Referred by: ____

Present Health Concerns:

Current Health Condition(s):____

Present Symptoms:____

Current medications/treatments:____

Have you ever tried reflexology before? Y N Was your experience beneficial? Y N N/A

Medical History

List previous operations/accidents: List other alternative therapies you have tried:

_____________________________________ _______________________________________

List any medical condition experienced in the last 12 months:

____

I, ____ consent to reflexology treatment.

____

Signature/Date