REFLEXOLOGY INTAKE FORM

Shelly Buhr Reflexology

General Information

Name: _____ Birth Date: _____

Address: _____ Home Phone: _____

City: _____ Province: _____ Cell Phone: _____

Postal Code: _____ Bus. Phone: _____

Occupation: _____ How long?_____

Age: _____ Weight: _____ Height: _____

Family Physician: _____ Clinic Phone: _____

Factors That Could Affect This Session

Are you pregnant? ◯ Yes / ◉ No Had other pregnancies ◯ Yes / ◉ No

Are you presently experiencing any of the following?

- ☐ Headache
- ☐ Pain
- ☐ Inflammation
- ☐ Sunburn
- ☐ Skin Rash
- ☐ Burns
- ☐ Bruises
- ☐ Cuts
- ☐ Cold / Flu
- ☐ Decreased Range of Motion
- ☐ Cancer
- ☐ Herpes
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV / AIDS

Do you know of any other conditions that may alter the treatment of this session?

_____

Do you wear any prostheses? Such as:

- ☐ Glasses
- ☐ Contacts
- ☐ Glass Eye
- ☐ Metal plates
- ☐ Pins / Rods
- ☐ Artificial joints or limbs
- ☐ Dentures
- ☐ Hearing Aids
- ☐ Breast
- ☐ Other: _____

Current conditions of the foot or lower leg:

- ☐ Plantar Wart
- ☐ Athlete's Foot
- ☐ Arthritis Pain
- ☐ Bunion(s)
- ☐ Varicose Veins
- ☐ Gout
- ☐ Gangrene
- ☐ Phlebitis
- ☐ Neuropathy/Ulceration
- ☐ Tendonitis
- ☐ Fracture of Bones
- ☐ Ingrown Toenail
- ☐ Blisters / Cuts
- ☐ Plantar Fasciitis/Heel Spur
- ☐ Diabetes Concerns

Medications and Supplements

Please list any **regular medications** (**prescription and over the counter)** you take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any regular **vitamin**, **mineral** or **herbal** supplements you take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Exercise

How often do you exercise weekly? _____

What types of exercise? _____

_____

How long do you exercise? _____

Allergies / Intolerances

Are you allergic to medicines? Which ones? _____

_____

Do you have food allergies / intolerances? Which ones? _____

_____

_____

Do you have environmental allergies? Which ones? _____

_____

_____

Operations / Injuries / Health Conditions / Illnesses / Stresses

Please list any **operations** and the year in which they occurred:

_____

_____

_____

_____

Please list **injuries or accidents** that you have had and the year in which they occurred:

_____

_____

_____

_____

Please list any **health conditions**, **illnesses or hospitalizations** you have had and the year in which they occurred:

_____

_____

_____

_____

Please list any **stressors affecting your life** and for how long:

_____

_____

_____

_____

Nutrition and Habitual Use of Substances

Check in the appropriate column your rate of consumption.

SUBSTANCE	NONE	LIGHT	MODERATE	HEAVY
Water	_____	_____	_____	_____
Salt	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Un-prescribed Drugs	_____	_____	_____	_____
Fruits	_____	_____	_____	_____
Vegetables	_____	_____	_____	_____
WHOLE Grains	_____	_____	_____	_____
Red Meat / Pork	_____	_____	_____	_____
Chicken	_____	_____	_____	_____
Fish	_____	_____	_____	_____
Beans, Lentils, Nuts, Tofu	_____	_____	_____	_____
Dairy	_____	_____	_____	_____

Do I have permission to contact you regarding appointment changes, promotions and session content? ◉ **YES** / ○ **NO**

Consent to Receive Treatment

I, the undersigned, consent to reflexology treatment and understand that sessions are for the purpose of stress reduction and relaxation. I may stop the session at any time, either during the assessment or the treatment today as well as during any future sessions. Reflexology is not a substitute for professional medical help.

Signature _____ **Date** _____