Reflexology Intake

Dragan Lazetic

Date: _____

Name: _____ Date of Birth(dd/mm/yy): _____

Have you received Reflexology before? Y / N Did your health care provider refer you for this treatment? Y / N

If so please provide their name and address: _____

_____

How is your overall health? _____

_____

Primary Care Physician - name and address: _____

_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular: Heart disease ☐ Heart attack ☐ Blood clots ☐ Fainting ☐ Stroke / CVA ☐

Pace maker or similar device ☐ Blood pressure - High / Low

Respiratory: Chronic cough ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Shortness of breath ☐

Head and Neck: Headaches ☐ Migraines ☐ Vision problems ☐ Vision loss ☐ Ear problems ☐ Hearing Loss ☐

Infections: Hepatitis ☐ TB ☐ HIV ☐ Herpes ☐ Plantar warts ☐

Women: Are you pregnant - due date _____ Gynaecological conditions - what _____

Other Conditions: Epilepsy _____ Diabetes - onset _____ Loss of sensation - where _____

Allergies / sensitivities to what _____ Reaction? _____

Cancer - where _____ Arthritis _____

Skin conditions _____

Current medications: _____

Conditions being treated _____

Are you receiving treatment from another health care professional - who and what for? _____

_____

Surgeries: _____

Injuries: _____

Internal Pins, wires, artificial joints etc: _____

Reason for Reflexology: _____

Thank you for taking the time to fill out this questionnaire, it will assist us in providing the best treatment for you. Confidential when completed.

Consent for Assessment and Treatment

I understand the purpose of an assessment is to determine if Reflexology is indicated for me.
The nature and purpose of the assessment will be discussed and I will be given the opportunity to ask questions.

I will be informed of the proposed treatment plan and will be given the opportunity to ask questions.
Prior to the treatment I will be informed of the area's which will be treated.

I understand I have the ability to refuse, alter or rescind consent at any time throughout the treatment.

I have honestly answered the health history questions, and understand the importance of informing my therapist of any change.

I understand the nature and purpose of the Reflexology treatment and therefore give my consent to start treatment.

_____ _____
Signature of Client Date

_____ _____
Signature of Guardian (if applicable) Date

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