



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