RAC Reflexology Health Record

Date:_____ Name:_____ Date of Birth_____

Address:_____ City:_____

Province_____ Postal Code_____ Email:_____

Phone Number (H) _____ (W) _____ (C) _____

1. What is your occupation? _____
2. Are you in good health? Yes☐ No☐ Explain:_____
3. Are you undergoing other therapies? Yes ☐ No☐ If yes, list:_____
4. What else are you doing for your health? _____
5. What are your objectives/expectations for this session? _____
6. When did you last visit your doctor? _____

   Reason:_____
7. List past surgeries/injuries and time of same:_____
8. Are you taking medications? (Include vitamins & dietary supplements) Yes ☐ No☐

   If yes, list:_____
9. Do you sleep well? Yes ☐ No☐If no, explain:_____
10. Do you suffer from anxiety or worry? Yes ☐ No☐ Explain:_____
11. Is your blood pressure: Normal ☐High ☐ Low☐ Stable☐ Erratic☐ Explain:_____
12. Are you pregnant? Yes ☐ No ☐ If yes, which trimester?_____
    a. Have you had other pregnancies? Yes ☐ No☐ If yes, was there complications? _____
13. Do you have allergies/sinus conditions? Yes☐ No☐ If yes, explain:_____
14. Do you wear prostheses? (eg. Glasses, contacts, glass eye, artificial joint/limb, metal plate, pins or wires, dentures, hearing aid) Yes☐ No ☐ If yes, list:_____
15. Are there any current problems with your health? Explain:_____
16. Is there anything else about your health you wish to discuss? _____

_____

Consent: I, the undersigned, consent to reflexology treatment and understand that the sessions are for the purpose of stress reduction and relaxation. Reflexology does not substitute for medical examination, diagnosis, or treatment and I will consult a physician, or other qualified medical specialist for all my mental or physical ailment(s) in which I am aware. I may stop the session at any time, either during the assessment or the treatment. Reflexology Therapists do not diagnose, prescribe, treat for specific conditions or use tools of any kind. I confirm that I have informed the therapist of all my known medical conditions and answered all questions honestly. Should I seek further Reflexology treatment from the therapist I agree to update them as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Signature:_____ Date: _____

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Are you presently experiencing any of the following?

Sunburn	☐	Inflammation	☐
Pain	☐	Headache	☐
Skin rash	☐	Cuts, bruises, burns	☐
Colds/Flu	☐	Decreased range of motion	☐

Other _____

Please indicate your consumption level of the following:

	NONE	LIGHT	MODERATE	HEAVY
Salt	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Water	☐	☐	☐	☐

Check the appropriate answer:

ENDOCRINE SYSTEM:

Diabetes	Yes ☐	No ☐	Past ☐
Hypoglycemia	Yes ☐	No ☐	Past ☐
Menopausal Problems	Yes ☐	No ☐	Past ☐
Hypothyroidism	Yes ☐	No ☐	Past ☐
Hyperthyroidism	Yes ☐	No ☐	Past ☐

Specify: _____

URINARY SYSTEM:

Kidney Disease	Yes ☐	No ☐	Past ☐
Kidney Stones	Yes ☐	No ☐	Past ☐
Urinary Problems	Yes ☐	No ☐	Past ☐

Specify: _____

CARDIOVASCULAR:

Heart Disease	Yes ☐	No ☐	Past ☐
Phlebitis	Yes ☐	No ☐	Past ☐
Varicose Veins	Yes ☐	No ☐	Past ☐
Circulation Problems	Yes ☐	No ☐	Past ☐
Anemia	Yes ☐	No ☐	Past ☐

Specify: _____

IMMUNE & LYMPHATIC:

Arthritis	Yes ☐	No ☐	Past ☐
Chronic Fatigue	Yes ☐	No ☐	Past ☐
HIV/AIDS	Yes ☐	No ☐	Past ☐

Specify: _____

MUSCULOSKELETAL:

Osteoporosis	Yes ☐	No ☐	Past ☐
Fibromyalgia	Yes ☐	No ☐	Past ☐
Bursitis	Yes ☐	No ☐	Past ☐
Gout	Yes ☐	No ☐	Past ☐
Back Pain	Yes ☐	No ☐	Past ☐
Scoliosis	Yes ☐	No ☐	Past ☐
Foot/Arm/Hand Problem	Yes ☐	No ☐	Past ☐

Specify: _____

RESPIRATORY:

Asthma	Yes ☐	No ☐	Past ☐
COPD	Yes ☐	No ☐	Past ☐
Emphysema	Yes ☐	No ☐	Past ☐
Tuberculosis	Yes ☐	No ☐	Past ☐

Specify: _____

NERVOUS:

Vision	Yes ☐	No ☐	Past ☐
Hearing loss/Problems	Yes ☐	No ☐	Past ☐
Nerve pain/Damage	Yes ☐	No ☐	Past ☐
Mental/Emotional Problems	Yes ☐	No ☐	Past ☐
MS	Yes ☐	No ☐	Past ☐

Specify: _____

REPRODUCTIVE:

PMS	Yes ☐	No ☐	Past ☐
Endometriosis	Yes ☐	No ☐	Past ☐
Prostate Problems	Yes ☐	No ☐	Past ☐

Specify: _____

DIGESTIVE:

Constipation	Yes ☐	No ☐	Past ☐
Diarrhea	Yes ☐	No ☐	Past ☐
Crohn's Disease	Yes ☐	No ☐	Past ☐
Colitis	Yes ☐	No ☐	Past ☐
Diverticulitis	Yes ☐	No ☐	Past ☐
Ulcer	Yes ☐	No ☐	Past ☐

Specify: _____

INTEGUMENTARY (SKIN):

Psoriasis	Yes ☐	No ☐	Past ☐
Eczema	Yes ☐	No ☐	Past ☐
Warts	Yes ☐	No ☐	Past ☐

Specify: _____

OTHER

Hepatitis	Yes ☐	No ☐	Past ☐
Herpes	Yes ☐	No ☐	Past ☐
Cancer	Yes ☐	No ☐	Past ☐

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