BODY&SOLE
REFLEXOLOGY

Name: _____Phone: (_____) _____ DOB: _____

Address:_____ City: _____State: _____ Zip: _____

E-mail: _____ Referred by: _____

Physician: _____ Health Insurance Carrier: _____

Occupation: _____ # Hrs. /Week: _____

Previous Occupation: _____

Number and age range of children: _____

Reason for therapy: _____

Emergency contact: _____ Phone: (_____) _____

Relationship to you: _____

How many hours/week do you participate in the following activities?

Walking _____	Running _____	Biking _____
Weight lifting _____	Calisthenics _____	Yoga _____
Sports _____	Meditation _____	Pilates _____

Other _____

Your typical breakfast: _____

Your typical lunch: _____

Your typical dinner: _____

CLIENT HEALTH HISTORY

Please list all medications & vitamins/supplements you're currently taking:

Name of Medication: Reason:

_____

_____

_____

_____

_____

Please check all that apply to you:

____ Auto Immune Disorders
e.g. Lupus, MS, etc.
____ Acid Reflux/Gas
____Allergies
____ Asthma
____ Arthritis/Joint Pain
____ Back Pain
____ Bruising easily
____ Cancers/Tumors
____ Carpel Tunnel Syndrome
____ Constipation
____ Irritable Bowel/Colitis/Crohn's
____ Depression/Anxiety
____ Fatigue/Insomnia
____ Fibromyalgia
____ Headaches/Migraines
____ Heart Disease
____ Hypertension
____ Low Immune System
____ Muscle Aches/Cramping
____ Poor Circulation
____ Prostate/Frequent Urination
____ Skin Disorders
____ Vertigo/Dizziness
____ Weight Management
____ Pregnant (If yes, complete box below)

Prenatal clients:

Prenatal Care Provider/Doctor _____ Telephone _____

May I have permission to contact your care provider? _____ My due date is _____

This is my _____ (1st, 2nd, etc.) pregnancy. This will be my _____ (number 1st, 2nd…) birth.

I am _____ (number) weeks pregnant in my _____ (1st, 2nd, 3rd) trimester.

RELEASE AND CONSENT AGREEMENT

Holistic Health Therapy strives to educate in the Art of Self-Care and is usually sought by those who seek optimum physical, psychological, and social well-being. The variety of therapies and techniques involve improving nutrition, reducing stress, eliminating self-destructive habits and lifestyle changes to enhance physical fitness, mental alertness, proper mental attitude towards others and an awareness of the wholeness and sacredness of the environment and ourselves.

I understand that it is not within the scope of a Reflexologist to diagnose illness, disease, or any physical or mental disorder, prescribe medical treatment or pharmaceuticals or perform spinal manipulations.

I understand the importance of communication in enhancing the therapeutic effects of the foot reflexology session. I will not hesitate to inform the Reflexologist of any discomfort felt during the session and to exchange feedback after the session. I have stated all my known medical conditions and take it upon myself to update my health status during subsequent visits.

I understand that the care involved may include direct body contact by the therapist to facilitate techniques designed to address physical, mental, and emotional stress-induced problems that prevent full integration of my capacities.

I release Body & Sole Reflexology, LLC from liability for any upsets, injuries, or physical/emotional distress resulting from my participation in any designated therapy.

Client Name Printed _____

Client Signature _____

Therapist Signature _____

Consent to Treatment of Minor:

By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of parent or guardian _____ Date _____