New Client Health History Form

Name_____Date: _____

Address_____ City _____State & zip_____

Phone #s: home ( )_____Cell ( ) _____Office ( ) _____

E-mail _____ Date of Birth_____ Age_____

Who may I thank for referring you? _____

Primary care physician_____ Phone # ( )_____

Please Use the Back of the Form for Additional Space (if Necessary)

1. Please indicate any problems with your face, feet, hands or ears that might affect my working on them.

_____

_____

2. Present health concerns: _____

_____

_____

3. Currently under medical care? Yes____ No____ If so, for: _____

_____

4. Medications or drugs now taking: _____

_____

5. Previous illnesses, accidents, surgery and/or broken bones: _____

_____

_____

6. When tense, where do you feel it: 1st_____ 2nd_____

7. For women: Are you pregnant? Yes _____ No _____

8. Why are you seeking reflexology? _____

9. Have you ever had reflexology before? _____ 10. Do you have a pacemaker? _____

Signature_____

**Complementary therapies, as the term suggests, should be used to complement the use of conventional medicine and should never take the place of appropriate medical advice.*