Integrative Reflexology Form

Full Name_____

Phone_____Email_____

Address_____

Occupation_____

Do you have or have had any of the following conditions/illnesses/problems?

- Arthritis
- Cancer
- Circulatory problems
- Diabetes
- Heart conditions
- High/low blood pressure
- Spinal/Skeletal problems

Elimination problems
Allergies/Asthma
Headaches
Depression
Anxiety
Insomnia
Skin disorders

Muscular Injuries/Disease
Neurological problems
Reproductive problems
Infectious disease
Stroke history
Fertility issues
Pregnancy (delivery date)

General state of health: ***Poor*** ***Fair*** ***Good*** ***Very Good*** ***Excellent***

If not excellent, please describe why: _____

Are you currently taking medications? ***Yes*** ***No***

If yes, please list_____

For what condition_____

List any allergies:_____

Have you had any surgeries? ***Yes*** ***No***

If yes, please describe_____

Are you currently being treated for any conditions by a physician? ***Yes*** ***No***

If yes, please describe_____

Disclaimer

Foot Reflexology does not claim to treat or diagnose physical condition. For condition outside of the scope of my practice please contact a physician for medical treatment.

Client Signature_____Date_____

Deepika Green_____Date_____