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 ❑ If no, explain: _____

3. Are you undergoing other therapies? Yes ❑ No ❑
If yes, list:_____
What else are you doing for your health? _____

4. What are your objectives/expectations for this session? _____

5. When did you last visit your doctor? _____
Reason: _____

6. List past surgeries/injuries and date: _____

7. Are you taking medications (vitamins, dietary supplements)? Yes ❑ No ❑
If yes, list: _____

8. Do you sleep well? Yes ❑ No ❑ If no, explain: _____

9. Do you suffer from anxiety or worry? Yes ❑ No ❑ Explain: _____

10. Is your blood pressure: Normal ❑ High ❑ Low ❑ Stable ❑ Erratic ❑ Explain: _____

11. Are you pregnant? Yes ❑ No ❑ If yes, which trimester? _____
Have you had other pregnancies? Yes ❑ No ❑ If yes, were there complications? _____

12. Do you have allergies/sinus conditions? Yes ❑ No ❑ If yes, explain: _____

13. Do you wear prostheses? (Glasses, Contacts, Glass eye, Artificial joint/limb, Metal plate, Pins or wires, Dentures, Hearing aid) Yes ❑ No ❑ Circle or if other, list: _____

14. Are there any current problems with your health? Explain: _____

15. Is there anything else about your health you wish to discuss? _____

Indicate your consumption/activity level of the following:

	NONE	LIGHT	MODERATE	HEAVY
Salt				
Sugar				
Caffeine				
Tobacco				
Alcohol				
Water				
Exercise				

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 SYSTEM:
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 SYSTEMS:
Arthritis Yes ❑ No ❑ Past ❑
Chronic Fatigue Yes ❑ No ❑ Past ❑
HIV/AIDS Yes ❑ No ❑ Past ❑
Specify: _____

DIGESTIVE SYSTEM:
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: _____

Are you presently experiencing any of the following?
Sunburn ❑ Inflammation ❑
Pain ❑ Headache ❑
Skin rash ❑ Cuts, bruises, burns ❑
Colds/Flu ❑ Decreased range of motion ❑
Other _____

MUSCULOSKELETAL SYSTEM:
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 problems Yes ❑ No ❑ Past ❑
Specify: _____

RESPIRATORY SYSTEM:
Asthma Yes ❑ No ❑ Past ❑
COPD Yes ❑ No ❑ Past ❑
Emphysema Yes ❑ No ❑ Past ❑
Tuberculosis Yes ❑ No ❑ Past ❑
Specify: _____

NERVOUS SYSTEM:
Vision Yes ❑ No ❑ Past ❑
Hearing loss/Problems Yes ❑ No ❑ Past ❑
Nerve pain/Damage Yes ❑ No ❑ Past ❑
Mental Health Issues Yes ❑ No ❑ Past ❑
MS Yes ❑ No ❑ Past ❑
Specify: _____

REPRODUCTIVE SYSTEM:
PMS Yes ❑ No ❑ Past ❑
Endometriosis Yes ❑ No ❑ Past ❑
Prostate Problems Yes ❑ No ❑ Past ❑
Specify: _____

INTEGUMENTARY (SKIN) SYSTEM:
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 ❑
Specify: _____

I understand that the Reflexologist Therapist is providing reflexology services within their scope of practice as defined by the Reflexology Association of Canada. I hereby give consent for my therapist to provide these services for the purpose of stress reduction and relaxation. Reflexology does not allow or substitute for medical examinations, diagnosis or treatment of any specific ailments or concerns.
I confirm that I have notified my therapist of my known medical conditions honestly and completely and agree to update my therapist to any changes in my medical profile. I acknowledge that with any treatment there can be risks or side effects both negative and positive and that these have been discussed and explained to me and I assume full responsibility for those risks. If I experience any discomfort during my session, I will immediately inform the therapist so that pressure or techniques may be adjusted to my level of comfort. I understand that I may stop the session or revoke my consent for treatment at any time.
The therapist reserves the right to refuse therapy on anyone they deem to have a condition for which reflexology may be contraindicated. I understand that any illicit or sexually suggestive remarks or action will result in immediate termination of the session.
I acknowledge that all information collected and contained within my file will be protected under the Privacy & Confidentiality Act. We will use this information only for the purposes of applying Reflexology sessions and will not be shared with anyone unless required by law or without your written consent to do so. We will retain your personal information for a period of seven years from your last appointment, will take measures to ensure safe storage of the information and will destroy information responsibly when retainment is no longer required. We are committed to providing you open access to your personal information but reserve the right to retain copies as per provincial and federal regulations or statutes.
I have read and understand the above consent and I have had the opportunity to participate in the development of my care plan and ask questions. By signing this consent form, I confirm my intent to move forward with reflexology sessions.

Name: _____

Signature: _____ **Therapist Signature:** _____