REFLEXOLOGY - INTAKE FORM

87 Bridge Street West
Bancroft, ON K0L 1C0

416 837-0031
troymillerrmt@gmail.com

Patient Name _____ Date _____

Address _____ Date of Birth _____

City _____ Postal Code _____

Telephone (appointment reminders) _____ Email _____

What are your health concerns? _____

_____

_____

What other therapies have you tried for these concerns? _____

_____

Check all that apply to you:

- ❑ Taking medications
- ❑ Past serious illness
- ❑ Difficulty sleeping
- ❑ Heart COndition
- ❑ Asthma
- ❑ Arthritis
- ❑ Other _____
- ❑ Past surgeries
- ❑ Diabetic
- ❑ Frequent headaches
- ❑ Abnormal blood pressure
- ❑ Sinus condition
- ❑ Menstrual problems
- ❑ Currently pregnant
- ❑ Past serious accident
- ❑ Hypoglycemic
- ❑ Severe headaches
- ❑ Allergies
- ❑ Skin condition
- ❑ Menopausal symptoms

With regard to your feet, check if you have (or have had) any of the following:

- ❑ Broken bones
- ❑ Sprains
- ❑ Cuts (or scars)
- ❑ Other _____
- ❑ Tender spots
- ❑ Bunions
- ❑ Ingrown toenails
- ❑ Tendon problems
- ❑ Hammer toes
- ❑ Skin problems

Check if you have (or have had) problems associated with the following systems:

- ❑ Endocrine
- ❑ Urinary
- ❑ Cardiovascular
- ❑ Immune / Lymph Nodes
- ❑ Musculo-skeletal
- ❑ Digestive
- ❑ Respiratory
- ❑ Neurologial
- ❑ Reproductive

I hereby attest to the the truth contained in the above and voluntarily agree to one or more reflexology treatments. I full understand that reflexology is not meant to substitute as treatment for any medical condition; and I render the reflexologist harmless with respect to any effects experienced as a result of any current and future reflexology treatments.

Signature _____ Date _____