R.A.C. REFLEXOLOGY ASSOCIATION OF CANADA A.C.R. ASSOCIATION CANADIENNE DE REFLEXOLOGIE

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 time of same: _____
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? (eg. Glasses, contacts, glass eye, artificial joint/limb, metal plate, pins or wires, dentures, hearing aid) Yes ❑ No ❑ If yes, list: _____
14. Are there any current problems with your health? Explain: _____
15. Is there anything else about your health you wish to discuss? _____

Consent: I, the undersigned, consent to reflexology treatment and understand that the sessions are for stress reduction and relaxation. Reflexology does not substitute for medical examination, diagnosis, or treatment and I will consult a physician, or other qualified medical specialist for all my mental or physical ailments of which I am aware. I may stop the session at any time, either during the assessment or the treatment. Reflexology therapists do not diagnose, prescribe, treat for specific conditions or use tools of any kind. I confirm that I have informed the therapist of my known medical conditions and answered all questions honestly. Should I seek further reflexology treatment from the therapist, I agree to update them as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Signature: _____ Date: _____

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HEALTH RECORD

Are you presently experiencing any of the following?

Sunburn	☐	Inflammation	☐
Pain	☐	Headache	☐
Skin rash	☐	Cuts, bruises, burns	☐
Colds/Flu	☐	Decreased range of motion	☐

Other _____

Indicate your consumption/activity level of the following:

	NONE	LIGHT	MODERATE	HEAVY
Salt	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Water	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Check the appropriate answer:

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: _____

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: _____

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: _____

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 ☐