Orlando Reflexology

Name:
Address:

Tel:
DOB:
Email:
Referred by:
Occupation:
Marital status:
Recent surgeries:
Injuries:

If you are taking medications, if so, what they are taken for:

Have you had Reflexology before, and was it helpful?

Problems in any of these areas, circle them please:
Spine where_____ Neck where_____ TMJ, Whiplash
Neuropathy, IBS, Fibromyalgia, Migraines, Indigestion, Insomnia,
Anxiety, Panic Attacks, Pain, Fertility, Cycles, Restless Leg Syndrome,
Sinus, PTSD, Allergies, Arthritis, Hormones, Stress related illness,
_____, _____, _____

Any other health challenge or something I would need to know?

Do you have athlete's foot or a fungal infection or a contagious infection presently?

What outcome(s) are you hoping for from your Reflexology treatment?

Please take a moment to carefully read the following information and sign where indicated.

If you have a specific medical condition or specific symptoms, any services may be contraindicated. A referral from your primary care provider may be required prior to service. I understand that the services I receive are provided for the basic purpose of relaxation and relief of tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that it can be adjusted to my level of comfort. I further understand that any services provided should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. Because services should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I fail to do so.

Client Signature_____

Date_____

Consent to Treatment of **Minor**: By my signature below, I hereby authorize _____ to administer, Reflexology or EFT to my child or dependent as they deem necessary

Signature of Parent or Guardian: _____Date:_____

***Please be in touch before your session to put a credit card on file in case of last minute cancellations, (there will be a 50% surcharge)**