



REFLEXOLOGY HEALTH RECORD

THIS FORM IS TO BE COMPLETED BY THE CLIENT FIRST THEN BY PRACTITIONER FOR INITIAL SESSION THIS PROCESS IS NECESSARY SO THAT THE CLIENT GIVES THEIR STORY FIRST WITHOUT PROMPTING OR LEADING. THE PRACTITIONER THEN GOES BACK OVER THE FORM IN DIFFERENT COLORED INK (SO THAT IT IS EVIDENT WHERE THE PRACTITIONER HAS ADDED) TO GAIN MORE INFORMATION. IF FORMS WERE USED IN COURT IT THEN BECOMES CLEAR WHAT INFO THE CLIENT HAS GIVEN.

Client				Date of Birth			
Telephone	Home			Business			Ext
Email Address							
Street #			Street Name				
City			Province			Postal Code	
Doctor's Name				Telephone			
Doctor's Address							

1. What is your occupation? _____
2. Are you in good health? Yes No Explain: _____
3. Are you undergoing other therapies? Yes No
 List The therapist has an obligation to work in conjunction with and not against other therapies that are being sought out by the client _____
4. What else are you doing for your health? _____
5. What are your goals/expectations for this session? The client has a right to determine their treatment focus and to work with the practitioner to achieve those goals _____
6. When did you last visit your doctor? This information gives info on any diagnosis that might have been made medically and what if anything they are being treated for. The Practitioner must be fully aware of and work alongside of the medical profession. Contraindications might be an issue depending on what has been diagnosed _____
 Reason _____
7. List past surgeries and time of same: practioner should be aware of recent or past surgeries that might affect the treatment or treatment plan for that person _____
8. List past injuries and time of same: same as above especially if injuries are in the area of the foot or lower leg _____

9. **Are you taking medications?** (Please include any vitamins or dietary supplements.) Yes No

Reasons for taking: **medications may have varying levels of side effects that could affect the treatment outcomes**

10. Do you sleep well? Yes No

Explain: _____

11. Do you suffer from anxiety or worry? Yes No

Explain: _____

12. **Is your blood pressure:** Normal High Low Stable Erratic

If the blood pressure is not stabilized and is erratic then the client should not be treated until it is.

Unstable blood pressure gives indications of underlying pathologies that the practitioner should be aware of. Client should be referred to doctor.

13. **Are you pregnant?** Yes No **If yes, which trimester?** 1st 2nd 3rd

in reflexology the first trimester may be contraindicated for treatment

14. Have you had other pregnancies? Yes No

15. **Do you have allergies/sinus conditions?** Yes No

List: **the practitioner needs to aware of allergies and reactions when using oils, creams etc. We do not want to trigger allergic reactions or sinus infections. Allergies and sinus conditions give indication to underlying pathologies in the body.**

16. **Do you have varicose veins?** **Practitioner should avoid working on reflexes found on the veins - on lower leg if not trained to work with varicose veins** Yes No

17. **Do you wear prostheses (e.g. glasses, contacts, glass eye, artificial joints/limbs, metal plates, pins, or wires, dentures, hearing aids?)** Yes No

List: **these point to underlying pathologies – as well dentures and contacts should be removed so for safety reason when the client goes into relaxation mode. Hearing aids allows the practitioner to communicate appropriately all information to the client in an appropriate manner so that it is heard and understood. Artificial joints/limbs, pins and metal plates and wires need to be worked with appropriately if found in the foot area.**

18. **Is there anything else about your health you wish to discuss?** Yes No

Explain: **Gives client opportunity to address all issues of their health**

19. **Are you presently experiencing any of the following?**

Sunburn Inflammation Pain Headache Skin Rash Cold/Flu

Cuts Bruises Burns Decreased Range of Motion

Other: **To give awareness to level of pressure and technique that should be used if any of these are a factor. Cold/flu and Headache would indicate a decrease in pressure and a shorter session**

20. Please indicate your consumption level of the following by placing an X in the appropriate column.

	None	Light	Moderate	Heavy
Salt				
Sugar				
Caffeine				
Tobacco				
Alcohol				
Exercise				
Water				

Consent to Receive Treatment Protects both the client and practioner

I, the undersigned, consent to reflexology treatment and understand that sessions are for the purpose of stress reduction and relaxation.

I may stop the session at anytime, either during the assessment or the treatment.

Reflexologists do not diagnose, prescribe medication for medical or psychological conditions, or treat for specific conditions.

Signature: _____ Date: _____

Do you have problems with any of the following systems?

Endocrine System	<i>(diabetes, hypoglycemia, menopausal problems, hypothyroidism)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Urinary System	<i>(kidney disease, urinary problems)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Cardiovascular	<i>(high/low blood pressure, heart disease, phlebitis, varicose veins, circulation problems, anemia, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Immune & Lymphatic	<i>(arthritis, chronic fatigue, environmental illness, HIV/AIDS, allergies, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Musculoskeletal	<i>(osteoporosis, fibromyalgia, bursitis, gout, back pain, scoliosis foot, arm or hand problems)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Respiratory	<i>(asthmas, emphysema, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Nervous System	<i>(vision, hearing loss/problems, loss of sensation, nerve pain/damage, mental or emotional problems, MS)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Reproductive	<i>(PMS, dysmenorrhoea, endometriosis, prostate problems, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Digestive	<i>(prolonged constipation, diarrhoea, Crohn's Disease, Colitis, diverticulitis, ulcer, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			
Integumentary (Skin)	<i>(Psoriasis, eczema, warts, etc.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify: _____			

Other Infectious Diseases and/ or contraindicated

Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If a client is experiencing pain, use the reminder phrase **OL DR FICARA**, when questioning the client to determine the following:

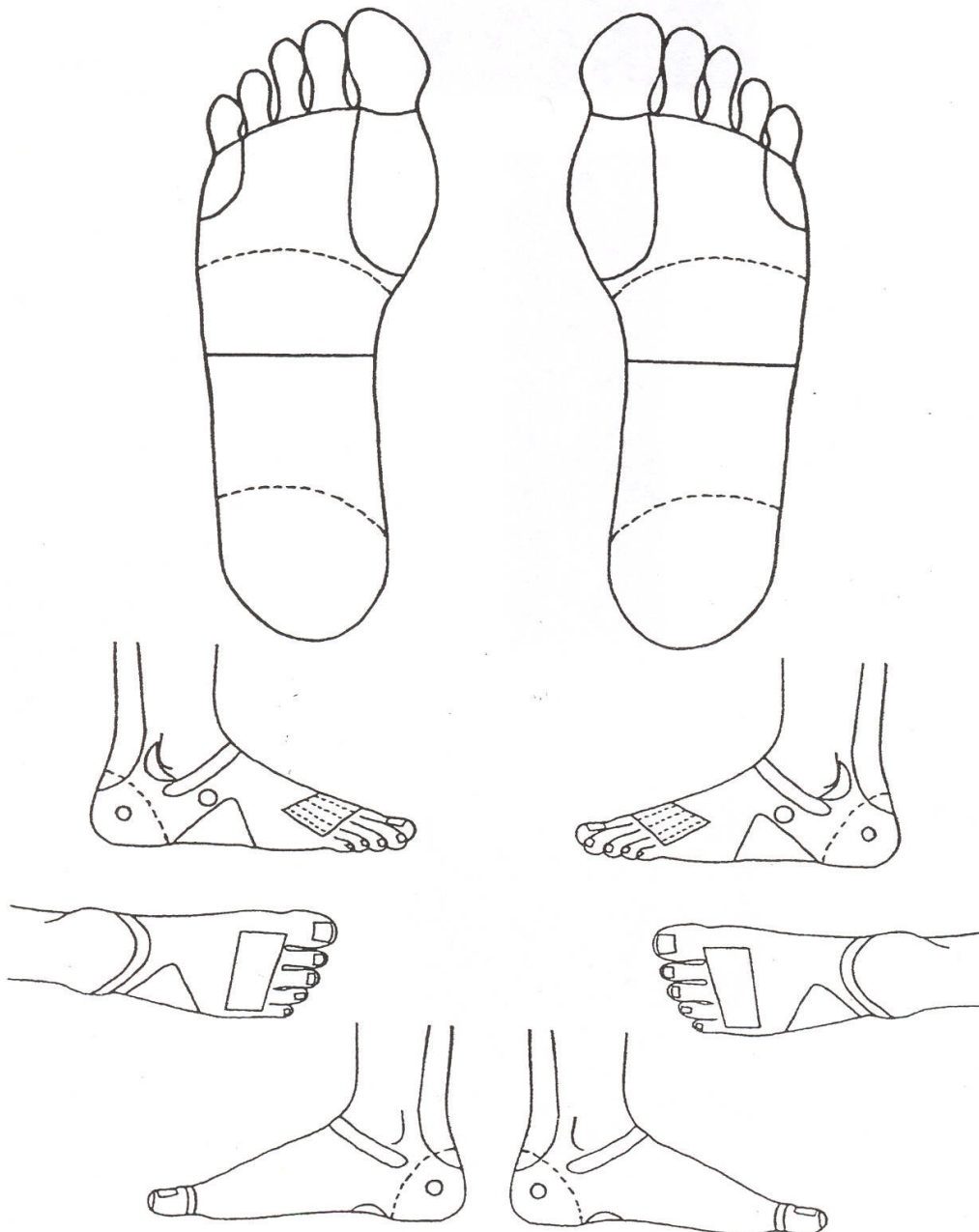
- | | | | | |
|------------------|-------------------|-------------------|---------------------------------------|-----------------------------|
| Onset? | Duration? | Frequency? | Character (dull, sharp, etc.)? | Relieving Factors? |
| Location? | Radiation? | Intensity? | Aggravating Factors? | Associated Symptoms? |

REFLEXOLOGY INITIAL TREATMENT RECORD

THIS FORM IS FILLED OUT FOR THE INITIAL SESSION AS THIS IS WHEN THE FIRST ASSESSMENT IS COMPLETED. EVERYTHING OUT OF THE ORDINARY IS PLACED ON THIS FORM NO MATTER HOW MINOR. THE FORM IS BIG ENOUGH TO CONTAIN THE INFO. A GLOSSARY OF SYMBOLS MUST BE PREPARED BY THE PRACTITIONER SO THAT IF SYMBOLS ARE USED TO DENOTE SOMETHING THEN THIS GLOSSARY CAN BE REFERRED BACK TO AT ANY TIME BY EITHER THE PRACTITIONER OR BY THOSE WHO HAVE BEEN GIVEN PERMISSION BY THE CLIENT IN WRITING TO ACCESS THE DOCUMENTATION. THE CLIENT MAY ACCESS THIS INFO AT ANY TIME.

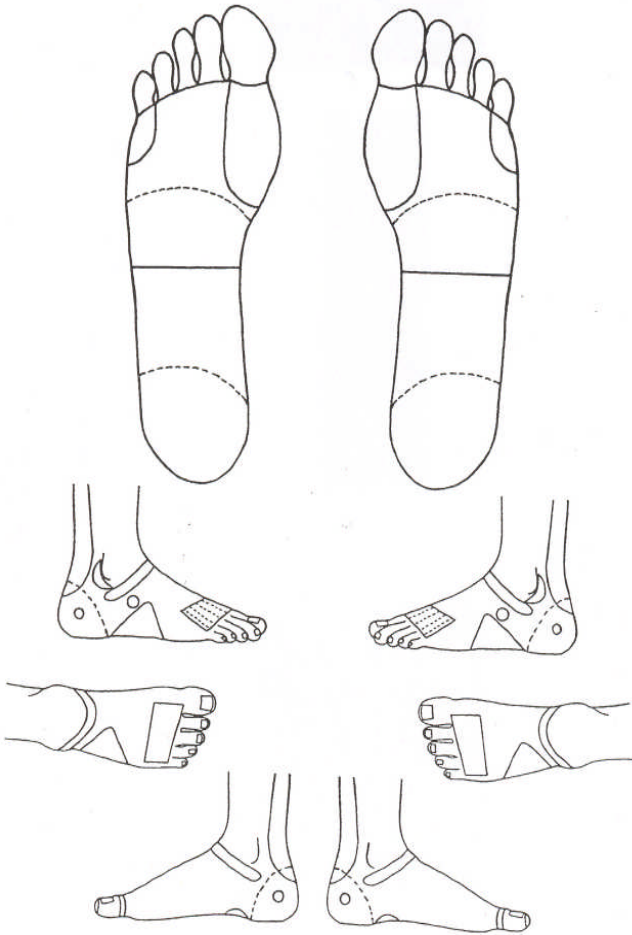
Client: _____

Date of Initial Session: _____



Client: Questions are within standard charting protocol

Date: _____



Felt Last Treatment

Felt Since Treatment

Feels Today

Observations of Client

Foot Observations

Right

Left

Findings During Treatment

Action Taken

Results

Clients Comments

Final Observations

Treatment Notes

