

New Client Health History Form

Name _____ Date: _____

Address _____ City _____ State & zip _____

Phone #: home () _____ Cell () _____ Office () _____

E-mail _____ Date of Birth _____ Age _____

Who may I thank for referring you? _____

Primary care physician _____ Phone # () _____

Please Use the Back of the Form for Additional Space (if Necessary)

1. Please indicate any problems with your feet, hands or ears that might affect my working on them.

2. Present health concerns: _____

3. Currently under medical care? Yes _____ No _____ If so, for: _____

4. Medications or drugs now taking: _____

5. Previous illnesses, accidents, surgery and/or broken bones: _____

6. When tense, where do you feel it: 1st _____ 2nd _____

7. For women: Are you pregnant? Yes _____ No _____

8. Why are you seeking reflexology? _____

9. Have you ever had reflexology before? _____

10. Do you have a pacemaker? _____

Signature _____

**Complementary therapies, as the term suggests, should be used to complement the use of conventional medicine and should never take the place of appropriate medical advice.*