

Reflexology Health Consultation

Personal Information:

Name: D.O.B. Gender: M / F
Address: Postal Code:
Home Phone: Work Phone: Cell Phone:
Marital Status: Email:
Occupation:

Medical History:

Name & Address of Doctor:
Serious Childhood Illness:
Surgical Operations (within last 5 years):
.....
Chronic Illnesses:
Familial Medical Conditions:

Medications:

Prescribed by a Doctor:
.....
Self-prescribed:
.....

Medical Conditions:

Digestive System (IBS, Colitis, Constipation, Reflux, etc.):
.....
Endocrine System (Hormonal, Diabetes, Hypoglycemia, Menopause, etc.):
.....
Respiratory/Circulatory Systems (Heart, Blood Pressure, Lungs, Sinusitis, etc.):
.....
Skeletal/Muscular Systems (Arthritis, Back, Neck, Muscular/Joint problems, etc.):
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Urinary System (Cystitis, Incontinence, Kidney Stones, Infection, etc.):
.....
Allergies:
Headaches/Migraines:
Notes:
.....

Female Section:

Do you have any problems with the following: menstrual cycle, PMS, Endometriosis, Fibroids,
Menopausal, etc.
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Are you pregnant, or trying to get pregnant?

