



PEACE FOR YOUR FEET REFLEXOLOGY

NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 HOME PHONE _____ WORK _____
 CELL PHONE _____ DATE OF BIRTH _____
 EMAIL _____
 REFERRED BY _____
 HOBBIES _____
 AGE _____ MALE _____ FEMALE _____
 Would you like to be on our e-mail list? _____yes _____no

IN CASE OF EMERGENCY:

NAME: _____ PHONE _____

Have you ever experienced a reflexology session before? ___NO ___YES

If yes, how recently? _____

<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Calluses, bunions, corns, etc?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot surgeries?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Injuries in past two years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tension or soreness in specific area?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hormonal or metabolic issues?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive to touch in any area?
<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness or stabbing pains?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus or allergy issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Digestive Issues?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other medical conditions?

DETAILS ABOUT ISSUES YOU MARKED "YES": _____

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED. If you have a specific medical condition or specific symptoms, bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialists for any mental or physical ailment that of which I am aware. I understand that bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. 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 forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment for the scheduled appointment.

CLIENT SIGNATURE: _____ DATE: _____

PRACTITIONER SIGNATURE: _____ DATE: _____

I HEREBY AUTHORIZE BODYWORK TECHNIQUES TO MY CHILD OR DEPENDENT AS DEEMED NECESSARY

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____