

REFLEXOLOGY CLIENT HEALTH FORM

Name: _____

Birth Date: / /

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____ Referred by: _____

What are some of the expectations you have of this treatment? _____

Health Status

List any medications that you are currently taking: _____

Please describe your current health condition: _____

Have you ever had any injury to your feet that resulted in surgery?

Yes No

If yes, please explain: _____
