Informed Consent to Reflexology

Please Read Carefully

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 any time, 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____

www.healthworkscentre.com 357 King St., Midland ON L4R 3M7 705 526 6900

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Reflexology

Date: ___________________

Please Read Carefully

An accurate health history is important to ensure that it is safe for you to receive reflexology. If your health status changes in future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law: or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Name: ____________________________________ Address: ______________________________________

City: ______________________________________ Province: ______________ Postal Code: ___________

Home Phone Number: ________________________ Occupation:________________________________

Cell Phone Number:_________________________ Birth Date: _______/_______/________/ Age: _______

Work Phone Number:_________________________ MM / DD / Year

Emergency Contact:__________________________ Physician Name: ______________________________

Emergency Phone #: ________________________ Physician Phone Number: _______________________

Email Address: ____

Circle one: Married Single Widowed Divorced Separated

Referred by: ____

IMPORTANT:

This for has to be completed by the client BEFORE the Reflexologist starts with the initial session.

Reflexology Health Record

Name:____ Date:________________________________

Doctor:____ Doctor Tel.: ____________________________

Doctor Address: ____

1. What is your occupation? ____
2. Are you in good health? Yes O No O
3. Are you undergoing other therapies? Yes O No O

   List: ____

4. What else are you doing for your health? ____
5. What are your goals/expectations for this session? ____
6. When did you last visit your doctor?____

   Reason: ____

7. List past injuries and time of same: ____
8. Are you taking medications? (Please include any vitamins or dietary supplements) Yes O No O

   Reason for taking: ____

9. Do you sleep well? Yes O No O

   Explain: ____

10. Do you suffer from anxiety or worry? Yes O No O

    Explain: ____

11. Is your blood pressure:

    Normal O High O Low O Stable O Erratic O

12. Are you pregnant? Yes O No O

    If yes, which trimester? 1 O 2 O 3 O

13. Have you had other pregnancies? Yes O No O

14. Do you have allergies/ sinus condition? Yes O No O

    List: ____

15. Do you have varicose veins? Yes O No O

16. Do you wear prostheses (e.g. glasses, contacts, glass eye, artificial joints/limbs, pins or wires, dentures, hearing aid ?) Yes O No O

    If yes, please list it: ____

17. Is there anything else about your health you wish to discuss?

    ____

18. Are you presently experiencing any of the following?

    Sunburn O Inflammation O Pain O Headache O Skin rash O

    Cold/ flu O Cuts, bruises, burns O Decreased range of motion O Other O

19. Please indicate your consumption level of the following

	NONE	LIGHT	MODERATE	HEAVY
Salt	O	O	O	O
Sugar	O	O	O	O
Caffeine	O	O	O	O
Tobacco	O	O	O	O
Alcohol	O	O	O	O
Exercise	O	O	O	O
Water	O	O	O	O

CONSENT TO RECEIVE TREATMENT

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Signature____________________________ Date____________________________

Do you have any problems with any of the following systems?

ENDOCRINE SYSTEM: Yes O No O
(e.g. diabetes, hypoglycemia, menopausal problems, hypothyroidism, hyperthyroidism)

Specify: ____

URINARY SYSTEM: Yes O No O
(E.g. kidney disease, urinary problems)

Specify: ____

CARDIOVASCULAR: Yes O No O
(e.g. High/low blood pressure, heart disease, phlebitis, varicose veins, circulation problems, anemia, etc.)

Specify: ____

IMMUNE & LYMPHATIC: Yes O No O
(e.g. arthritis, chronic fatigue, environmental illness, HIV/AIDS, allergies, etc.)

Specify: ____

MUSCULOSKELETAL: Yes O No O
(e.g. osteoporosis; fibromyalgia; bursitis; gout; back pain; scoliosis; foot, arm, or hand problems)

Specify: ____

REPIRATORY: Yes O No O
(e.g. Asthma, emphysema, etc.)

Specify: ____

NERVOUS: Yes O No O
(e.g. vision, hearing loss/problems; loss of sensation; nerve pain/ damage; mental or emotional problems, MS)

Specify: ____

REPRODUCTIVE: Yes O No O
(e.g. PMS, dysmenorrhoea, endometriosis, prostate problems, etc.)

Specify: ____

DIGESTIVE: Yes O No O
(e.g. prolonged constipation, diarrhea, Crohn's Disease, colitis, diverticulitis, ulcer, etc.)

Specify: ____

INTEGUMENTARY (SKIN): Yes O No O
(e.g. psoriasis, eczema, warts, etc.)

Specify: ____

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OTHER:

Tuberculosis	Yes O	No O
Hepatitis	Yes O	No O
Herpes	Yes O	No O
Cancer	Yes O	No O
HIV/AIDS	Yes O	No O

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

Onset?

Location?

Character (dull, sharp, etc.)?

Duration?

Radiation?

Aggravating factors?

Frequency?

Intensity?

Associated symptoms?

Relieving factors?

Notes: