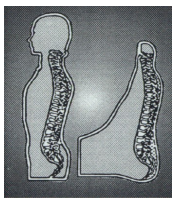

Seattle Reflexology & Massage Center
P. O. Box 22
Clinton, Washington 98236
(206) 284-8389
www.seattle-reflexology.com

For Office Use Only:
□ *DB*
□ *MC*

Name:_____ DOB: _____ Age: _____

Address: _____ Preferred phone #: _____

City, State: _____ Zip: _____ Where did you hear about us? _____

Emergency contact/phone/relationship: _____ E-mail address: _____

Preferred mode of communication from/with us: __ email __ text __ call
Please check this box if you do not want to be included in our occasional newsletter distribution □

Is this your first reflexology session? Yes / No What size shoe do you wear? _____

What is your primary goal in coming here? _____

List any major illnesses, broken bones, surgeries, hospitalizations and the year they occurred: _____

_____

_____ (cont. on back)

List any western or naturopathic medications or herbs you are taking, as well as the reason. Are you on statins?:

_____

Are you utilizing other bodywork modalities and/or therapies? _____

Circle any that apply today: Fever Infection Cold/flu Pain Inflammation Where? _____

**** Please take a moment to consider any emotional traumas that have occurred during your life and reflect upon whether / how they might relate to the onset of your physical symptoms.***

Do you have foot concerns? Yes / No With which foot? Right / Left / Both

Plantar fasciitis	Neuroma	Bunion	Plantar warts	Hammer toes/corns	Swelling
Athlete's foot	Bone spur	Gout	Toenail fungus	Other_____	

If you are receiving care from another health care practitioner, please answer the following:
Practitioner's name: _____ Phone: _____
Reason: _____

Please mark "C" next to the current/chronic issues below and "P" next to those you've had in the past:

Deep vein thrombosis	**Pregnant/trying?**	Diabetes	Cholesterol	Cancer/location: _____	
Cong. heart failure	Endometriosis	Constipation	Sciatica	Osteoarthritis	
Embolism/clots	Ovarian cysts	Irritable bowel	Low back pain	Rheumatoid arthritis	
Phlebitis	Menstrual concerns	Diverticulitis	Jaw issues/TMJ	Neck/spinal injury	
Varicose veins	Prostate issues	Food allergies	Cramps	Bursitis/tendonitis	
Blood pressure H / L	Peri/menopause	Hemorrhoids	Sprains/strains	Joint disorder	
Anxiety	Parkinson's	Kidney/bladder issue	Osteoporosis	Chronic/acute pain/location: _____	
Depression	Dementia	Renal failure	Thyroid disorder	Asthma	Troubled sleep
Paralysis	Numbness	Urinary tract inf.	Allergies/hay fever	Sinusitis	Grief/trauma
Bipolar	Epilepsy/seiz	Rashes / Eczema	Autoimmune issues	Shallow breathing	Abuse history
Ear issues	Migraines/HA	Balance/walking issues	Exhaustion	Drug/alcohol/cig use	Stress 1-10 __

Area of your body that most reacts to stress: _____ Other issues:: _____

The above information is current, accurate and true to the best of my knowledge. I understand no diagnoses are implied or offered. **I agree to give at least 24 hours notice if I must cancel an appointment** and understand that I will be charged the full session price without such notice, except in cases of illness or emergency.

Signed: _____ Date: _____

Foot Measurement

Right	***Left***
TH ___	TH ___
BH ___	BH ___
W ____	W____