



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: _____ Email address: _____

Emergency contact/phone: _____ Where did you hear about us? _____

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 and the reason. Are you on **statins**? Y/N

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 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
Athlete's foot	Bone spur	Gout	Toenail fungus
			Hammer toes/corns Swelling
			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 | Allergies: food/air/env | Cramps | Bursitis/tendonitis |
| Blood pressure H / L | Peri/menopause | Hemorrhoids | Sprains/strains | Joint disorder |
| Anxiety | Parkinson's | Kidney/bladder issue | Crohns/Celiac | Chronic/acute pain/location: _____ |
| Depression | Dementia | Renal failure | Osteoporosis | Asthma |
| Paralysis | Numbness | Urinary tract inf. | Thyroid disorder | Sinusitis |
| Bipolar | Epilepsy/seiz | Rashes / Eczema | Autoimmune issues | Shallow breathing |
| 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 issue? _____

*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 _____