CLIENT INTAKE - REFLEXOLOGY

Name: _____ DOB:_____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Email: _____

Occupation: _____ Years:_____

General Practitioner: _____Phone: _____

In case of an emergency who would you like us to contact? Phone: _____

Name: _____ Relationship: _____

Have you ever had reflexology before? O Yes O No If so, when _____
What brings you in today? Please concerns and goals. _____

_____

_____

Are you currently receiving Medical/Therapeutic treatment? O Yes O No
If yes, for what condition? Please explain.

_____

_____

List any medications and the reason you take, including over the counter drugs and herbal/supplements: _____

_____

_____

List previous major illnesses, accidents, surgeries or broken bones, especially in your legs/feet or arms/hands: _____

_____

_____

For the purpose of receiving foot/hand bath please list all allergies: _____

_____

CLIENT INTAKE - REFLEXOLOGY

Please mark and (X) on any of the following that you are currently experiencing or have experienced in the past:

O Pregnancy	O Athletes Foot	O Warts
O Blood Clot (especially in legs/feet)	O Osteoporosis	O Arthritis
O Cancer	O Pitting Edema	O Varicose Veins (In Feet)
O Contagious or Infectious Disease	O Poor Circulation	O Numbness/Tingling
O Peripheral Neuropathy	O Chronic Pain	O Muscle/Tendon Issues
O Heart Problems	O Frostbite/Burns	O Swelling (Feet/Hands)
O Unstable Blood Pressure	O Open Wounds	O Neuroma
O Organ Donor Recipient	O Gout	

Is there any other information you would like to share? _____

_____

_____

DISCLOSURE:
Inner Balance Solutions and its members refuse primary responsibility for the healthcare of any client. Reflexology is not a substitute for medical treatment and should not be construed as such. We are not able to diagnose any condition and strongly encourage that you be under the care of a general practitioner or other qualified medical specialist. We will work in a co-operative manner with other healthcare providers for the highest good of our clients. However, it is the responsibility of the client at any-time to disclose important heath information including but not limited to: changes to current condition, new conditions, changes to all medications, and other such information pertinent to your healthcare. If for whatever reason this information is not disclosed, there shall be no liability on the member's part or the part of Inner Balance Solutions. All information pertaining to your file is strictly confidential. We will not release any information without written consent. We have the right to refuse services should we feel for whatever reason that the services requested would not be in the best interest of the client. Inner Balance Solutions adheres to and conducts their practice within the laws pertaining to both national and local. Inner Balance Solutions members adhere to and conduct their services under the professional codes of ethics and standards of care set by each profession.

By signing this form, I certify that the above information is correct to the best of my knowledge. I give Inner Balance Solutions and its members the authorization to provide reflexology services to the best of their ability. I understand that I may discontinue a session at any time for any reason. If for whatever reason you are uncomfortable, please let us know.

I understand that I will be liable for payment of the scheduled session.

By signing below I acknowledge that I have read and understand all parts of this consent/intake and that I have had the opportunity to ask any questions with regard to any services being offered.

Client Signature: _____ Date: _____

If a client is under the age of 18 years old, authorization must be given by the legal guardian of that minor. By signing below you agree that you are the parent of the minor for which Aromatherapy services are being provided to.

Parent/ Legal Guardian Name (Printed):_____

Parent Signature: _____ Date: _____