PERSONAL HEALTH HISTORY

Last Name:_____ First Name: _____Date_____
Address:_____ City: _____ State:_____ Zip _____
Phone (Home)_____Work _____Cellular:_____
E-Mail address: _____
Date of Birth: _____Age: _____Place raised:_____
Married Single Divorced Significant Other Widow
Height: _____Weight:_____ Desired weight: _____
Allergies:_____ Sensitivities:_____
Occupation:_____Employer:_____
Emergency Contact: _____ Relationship: _____Phone_____
Referred By: _____
Children: Name(s), Age(s), **Living with you**?_____
_____

Are you currently under a doctor's care? _____For what? _____
Current practitioners:
Name:_____Address:_____Phone:_____
_____ _____ _____

What is your main complaint for your Reflexology Treatment today: (physical, emotional, etc)

1. _____
2. _____
3. _____

Have you ever received reflexology or other bodywork sessions? _____
Specify: _____How often: _____

Stressors in your life: (Rate stress level 1-10; Ten is the worst.)
Family: _____ Social: _____Work related:_____ Stress in your body? _____Other? _____
Where do you hold your tension? _____
Do you exercise? Yes No What? _____How often? _____How long?_____
Energy level and pattern? (**least and most productive time of day**)
_____

Are you pregnant? _____Due date: _____
Serious past illnesses? _____
_____

Accidents, Injuries and dates (old and new)?_____
_____
Hospitalizations and dates (old and new)?_____
_____
Current prescription medications?_____
_____
Current herbs and supplements? _____
_____

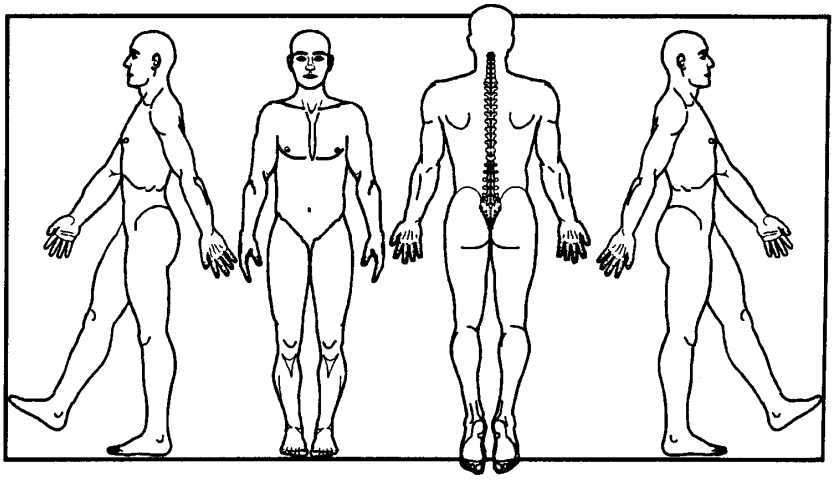
PERSONAL HEALTH HISTORY

Current Medical Concerns:

Osteoporosis	Asthma	Heart Problems	Stomach ulcers
Osteoarthritis	Diabetes	Breast Lumps	Cancer
Rheumatoid Arthritis	Hemophilia	Infections	Lupus
Blood Clots	Multiple Sclerosis	Liver Problems	Chronic Fatigue
Headaches	HIV	Epilepsy	

Other
Specify:_____
_____
_____
_____
_____
_____
_____

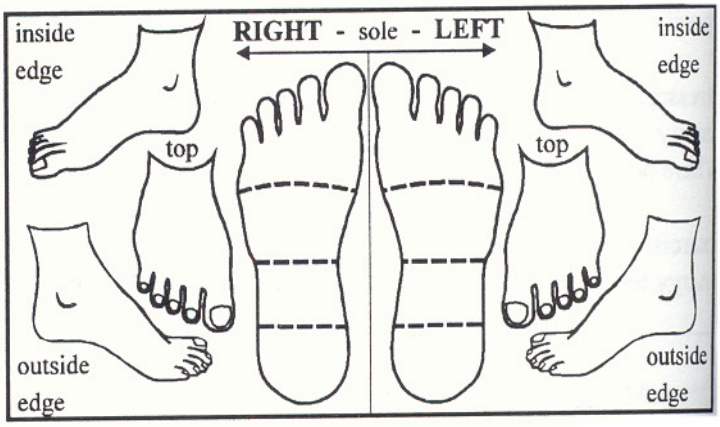
***Mark any area of concern on chart: (This can include pain)**



Foot Problems?_____Describe:_____

Corns	Warts
Puffiness	Bone Spur
Calluses	Unusual color or rash
Bunion	Current injuries, bruises
Hammer Toe	Ingrown toenail
Claw toe	Scars, past injuries

* **Mark areas on concern on foot chart**



<u>Wellness Continuum</u>

Please mark where you think you fall on this wellness continuum

Sick **Your optimum health**

Getting sick or better **OK** **Good**

Addictions:

Sugar	Smoking	Alcohol	Drugs
Caffeine	How many a day?_____	How much?_____	Describe:_____
Salt	How long?_____	How long?_____	_____

PERSONAL HEALTH HISTORY

SYMPTOM SURVEY
Check and fill in if applicable; PLEASE TAKE YOUR TIME

General:
- General Fatigue
- Loss of or excessive gain in weight
- Average hours of sleep per night_____
- Quality of sleep: Good; Fair; Poor
- Insomnia - What time do you wake up?_____
- Motion Sickness

Other:_____

Respiratory:
- Sinus Problems
- Difficulty breathing deeply
- Nosebleeds
- Frequent coughing
- Frequent colds/sore throats

Other:_____

Cardiovascular:
- Rapid or skipped beats
- Varicose veins
- Bruise easily
- Chest pain
- Cold hands/feet
- Shortness of breath with activity
- High blood pressure

Other:_____

Neuromuscular:
- Headaches
- Muscle pain Where? _____
- Muscle cramping
- Weakness in arms or legs
- Swollen joints
- Painful joints
- Frequent dislocations
- Jaw/pain tension (TMJ)
- Frequent bone fractures
- Memory loss
- Absent minded
- Numbness/tingling

Where?_____
Other:_____

Skin
- Skin eruptions
- Excessive sweating Where?_____
- Dry or oily skin
- Hair loss

Other: _____

Urinary:
- Frequent urination
- Involuntary escape of urine
- Burning/discharge on urination
- Weak urine stream
- Difficulty starting urine
- Constant urge to urinate
- Bedwetting
- Flank pain
- Number of times awaken in night to urinate_____
- Frequent urinary tract infections

Other:_____

Senses:
- Glasses/Contact Lenses
- Eyesight worsening
- Hearing difficulties
- Earaches
- Ringing in ears
- Dizzy/loss of balance

Other:_____

Digestive:
- Frequent indigestion
- Heartburn
- Gas/bloating
- Nausea/vomiting
- Abdominal cramps
- Frequency of bowel movements_____
- Alternating constipation/diarrhea
- Consistency of stools (circle): hard, firm, soft , loose
- Pain/itching in rectum
- Hemorrhoids
- Excessive or loss of appetite

Other:_____

Endocrine:
- Swollen glands
- Excessive thirst, hunger, sweating, urination
- Slow/fast metabolism
- Blood sugar imbalances
- Thyroid problem such as low energy

Other: _____

Men:
- Burning/discharge on urination
- Lumps/swelling of testicles
- Pain in prostate or testicles
- Sores on penis or scrotum
- Hernia
- Impotence

Other:_____

PERSONAL HEALTH HISTORY

Women:

Menses:

Do you have periods? Yes No

Frequency and duration
Amount of bleeding: scant, average, heavy, spotting
Color: bright red, dark red, pink
Clots? Color:_____
Bleeding between periods

Other:

_____

PMS:

Breast Lumps
Sore breasts
Irritable
Depressed
Emotional swings
Bloating

Other:

_____

Menopause:

Do you think you have started? Yes No
Irregular cycle time frame:_____
Spotting
Hot flashes
Vaginal dryness/itching
Depression

Other:

_____

Childbirth:

Number of pregnancies: _____
Number of births:_____
Miscarriages: Yes No
Premature births
Cesareans
Abortions

Other:

_____

Infections:

Vaginal pain/rash/irritation
Vaginal discharge Color:_____

Other: _____

Other: _____

Cancellation Policy:

So that I may better serve my clients, 24 hrs. notice is required for cancellation. You will be charged the full session with less than 24 hrs. notification.

Disclaimer:

1. I understand that this work does not constitute nor it is a substitute for medical treatment, but rather is a form of health maintenance. I realize that this therapist is not a doctor, and does not diagnose, prescribe or treat any specific conditions.
2. I understand and agree that I am responsible for keeping my therapist informed of any changes in my physical condition, as this could affect the treatment I receive.

Signature:_____Date:_____

(Do not write below this line)

Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____