R.A.C. A.C.R.
REFLEXOLOGY ASSOCIATION OF CANADA
ASSOCIATION CANADIENNE DE REFLEXOLOGIE

HEALTH RECORD

Date: _____ Name: _____ Date of Birth: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Email: _____

Phone Number (H): _____ (W): _____ (C): _____

1. What is your occupation? _____
2. Are you in good health? Yes ◯ No ◯ If no, explain: _____
3. Are you undergoing other therapies? Yes ◯ No ◯ If yes, list: _____

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

   Reason: _____
6. List past surgeries/injuries and time of same: _____
7. Are you taking medications (vitamins, dietary supplements)? Yes ◯ No ◯

   If yes, list: _____
8. Do you sleep well? Yes ◯ No ◯ If no, explain: _____
9. Do you suffer from anxiety or worry? Yes ◯ No ◯ Explain _____
10. Is your blood pressure: Normal ☐ High ☐ Low ☐ // Stable ☐ Erratic ☐ Explain: _____
11. Are you pregnant? Yes ◯ No ◯ If yes, which trimester? _____

    Have you had other pregnancies? Yes ◯ No ◯ If yes, were there complications? _____
13. Do you have allergies/sinus conditions? Yes ◯ No ◯ If yes, explain: _____
14. Do you wear prostheses? (eg. Glasses, contacts, glass eye, artificial joint/limb, metal plate, pins or wires, dentures, hearing aid) Yes ◯ No ◯ If yes, list: _____
15. Are there any current problems with your health? Explain: _____
16. Is there anything else about your health you wish to discuss? _____

Consent: I, the undersigned, consent to reflexology treatment and understand that the sessions are for stress reduction and relaxation. Reflexology does not substitute for medical examination, diagnosis, or treatment and I will consult a physician, or other qualified medical specialist for all my mental or physical ailments of which I am aware. I may stop the session at any time, either during the assessment or the treatment. Reflexology therapists do not diagnose, prescribe, treat for specific conditions or use tools of any kind. I confirm that I have informed the therapist of my known medical conditions and answered all questions honestly. Should I seek further reflexology treatment from the therapist, I agree to update them as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Signature: _____ Date: _____

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HEALTH RECORD

Are you presently experiencing any of the following?

Sunburn	❑	Inflammation	❑
Pain	❑	Headache	❑
Skin rash	❑	Cuts, bruises, burns	❑
Colds/Flu	❑	Decreased range of motion	❑

Other _____

Indicate your consumption/activity level of the following:

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

Check the appropriate answer:

ENDOCRINE SYSTEM:

Diabetes	Yes ◯	No ◯	Past ◯
Hypoglycemia	Yes ◯	No ◯	Past ◯
Menopausal Problems	Yes ◯	No ◯	Past ◯
Hypothyroidism	Yes ◯	No ◯	Past ◯
Hyperthyroidism	Yes ◯	No ◯	Past ◯

Specify: _____

URINARY SYSTEM:

Kidney Disease	Yes ◯	No ◯	Past ◯
Kidney Stones	Yes ◯	No ◯	Past ◯
Urinary Problems	Yes ◯	No ◯	Past ◯

Specify: _____

CARDIOVASCULAR SYSTEM:

Heart Disease	Yes ◯	No ◯	Past ◯
Phlebitis	Yes ◯	No ◯	Past ◯
Varicose Veins	Yes ◯	No ◯	Past ◯
Circulation Problems	Yes ◯	No ◯	Past ◯
Anemia	Yes ◯	No ◯	Past ◯

Specify: _____

IMMUNE & LYMPHATIC SYSTEMS:

Arthritis	Yes ◯	No ◯	Past ◯
Chronic Fatigue	Yes ◯	No ◯	Past ◯
HIV/AIDS	Yes ◯	No ◯	Past ◯

Specify: _____

MUSCULOSKELETAL SYSTEM:

Osteoporosis	Yes ◯	No ◯	Past ◯
Fibromyalgia	Yes ◯	No ◯	Past ◯
Bursitis	Yes ◯	No ◯	Past ◯
Gout	Yes ◯	No ◯	Past ◯
Back pain	Yes ◯	No ◯	Past ◯
Scoliosis	Yes ◯	No ◯	Past ◯
Foot/Arm/Hand problems	Yes ◯	No ◯	Past ◯

Specify: _____

RESPIRATORY SYSTEM:

Asthma	Yes ❑	No ❑	Past ❑
COPD	Yes ❑	No ❑	Past ❑
Emphysema	Yes ❑	No ❑	Past ❑
Tuberculosis	Yes ❑	No ❑	Past ❑

Specify: _____

NERVOUS SYSTEM:

Vision	Yes ◯	No ◯	Past ◯
Hearing loss/Problems	Yes ◯	No ◯	Past ◯
Nerve pain/Damage	Yes ◯	No ◯	Past ◯
Mental Health Issues	Yes ◯	No ◯	Past ◯
MS	Yes ◯	No ◯	Past ◯

Specify: _____

REPRODUCTIVE SYSTEM:

PMS	Yes ◯	No ◯	Past ◯
Endometriosis	Yes ◯	No ◯	Past ◯
Prostate Problems	Yes ◯	No ◯	Past ◯

Specify: _____

DIGESTIVE SYSTEM:

Constipation	Yes ◯	No ◯	Past ◯
Diarrhea	Yes ◯	No ◯	Past ◯
Crohn's Disease	Yes ◯	No ◯	Past ◯
Colitis	Yes ◯	No ◯	Past ◯
Diverticulitis	Yes ◯	No ◯	Past ◯
Ulcer	Yes ◯	No ◯	Past ◯

Specify: _____

INTEGUMENTARY (SKIN) SYSTEM:

Psoriasis	Yes ◯	No ◯	Past ◯
Eczema	Yes ◯	No ◯	Past ◯
Warts	Yes ◯	No ◯	Past ◯

Specify: _____

OTHER

Hepatitis	Yes ◯	No ◯	Past ◯
Herpes	Yes ◯	No ◯	Past ◯
Cancer	Yes ◯	No ◯	Past ◯