



CLIENT HISTORY

Name _____ Date _____
Address _____
City/State/Zip _____
Phone (Home) _____ Work _____ Cell _____
Date of Birth _____ Age _____

1. How would you rate the present state of your health?
Excellent Good Fair Poor
2. Are you currently under a doctor's care? If so, explain

3. For women, are you pregnant? Yes No
If yes, how long? _____
4. List other therapies besides conventional medicine in which you are currently participating.

5. Are you taking any medications?
If so, please list:

6. List previous major illnesses, accidents, surgeries or broken bones.

7. Are you experiencing any problems with your hands or feet? Yes No
If yes, please explain:

8. Where is tension most evident in your body? (i.e., neck, shoulders, stomach, etc.)

9. Why are you trying reflexology?

10. Have you ever had a reflexology session before? If yes, when, where and how often?

11. Give name of referring person, if appropriate.

CONTRACT FOR SERVICES

TO CLIENTS OF REFLEXOLOGY:

You need to know that:

1. I am NOT a doctor.
2. I do not practice medicine.
3. I do not diagnose or treat for a specific illness.
4. I do not prescribe or adjust medication.
5. Reflexology is not a substitute for medical treatment, but may be a complement to most types of therapy.

What is reflexology? Reflexologists believe a map of the entire body is duplicated on the feet and hands. Reflexology is a non-invasive complementary discipline involving the use of alternating pressure applied to the reflexes found within these reflective maps. The physical act of applying specific pressures using thumb, finger, and hand techniques results in relaxation, which in turn causes physiological changes in the body.

What does reflexology do?

1. Reflexology promotes stress reduction throughout the entire body, bringing about relaxation.
2. Reflexology naturally promotes balance and normalization of the body through the relaxation process.
3. Reflexology stimulates circulation and the delivery of oxygen and nutrients to the cells.

By signing this form, I agree to a reflexology session. I understand I may discontinue a session or series of sessions at any time. If I have been diagnosed by a licensed health care professional as having any disease, injury, or other physical or mental condition, I understand that I should inform the person who made the diagnosis about the sessions I will be receiving, and whether or not I intend to discontinue any treatment or therapy which had been previously ordered, prescribed or recommended by a licensed health professional. I understand that by discontinuing any such treatment or therapy I assume responsibility for any negative outcome resulting from discontinuing that treatment or therapy.

Signature _____

Date _____

Print Name _____

REFLEXOLOGY IS NOT A SUBSTITUTE FOR MEDICAL CARE. IF YOU ARE EXPERIENCING ANY SPECIFIC MEDICAL PROBLEM AND HAVE NOT SEEN YOUR MEDICAL DOCTOR, I RECOMMEND YOU DO SO TODAY.

AUTHORIZATION FOR RELEASE OF INFORMATION

Copies of your client documentation forms may be released to the American Reflexology Certification Board by your practitioner for grading as part of his/her efforts to be nationally certified through the ARCB testing program. Any information received by the ARCB will be held in the strictest of confidence and will not be disclosed outside the ARCB testing process. Upon completion of the candidate's examination any records submitted involving documentation of your sessions with the candidate will be destroyed by ARCB.

To: (Practitioner's name and address) _____

Permission is hereby authorized to release my documentation records as part of your testing process with the American Reflexology Certification Board.

Client name—please print _____

Client signature _____ Date _____