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? _____
12. Do you have allergies/sinus conditions? Yes ❑ No ❑ If yes, explain: _____
13. 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: _____
14. Are there any current problems with your health? Explain: _____
15. 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: _____

Reflexology Association of Canada
165B Garry Street, Winnipeg, MB R3C 1G7
T: 204-477-4909 F: 204-477-4955 Toll-Free: 1-877-722-3338 E: info@reflexologycanada.org
www.reflexologycanada.org

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 ☐

PRIVACY AND CONSENT FORM

Privacy of the client's personal information is important. I/We are committed to collecting, using, and disclosing personal information responsibly.

Personal Information

Personal information will be used for Reflexology practice purposes only.

This information is necessary:

- For the provision of professional Reflexology health care services provided to you.
- To administer this Reflexology practice.

Personal information includes all the information that you provided to us on our client information/ health/medical history form at the first visit and any subsequent visits.

Personal information may also include any information that you provided us during the normal course of communication between client and clinic/practice office staff.

We will use and disclose only the information:

- You provided to us;
- Or is provided by another person acting on your behalf;
- With your written permission.

Information Protection

I/we are committed to protecting your personal information. We have established Security measures, which have been implemented to properly manage and safeguard your personal information from loss, theft and unauthorized access.

Information Disclosure

1. Your personal information shall be disclosed to only those who have a need to know the specific information.
2. The specific information disclosed shall be restricted to only that information relevant to the recipient's need to know.
3. Those who have a need to know include other Reflexology Therapist and health care providers (i.e. personal physicians, naturopaths, chiropractors, etc.)
4. Further, the personal information disclosed to Complementary Health Benefit Providers is limited to only the personal information that is required by the provider.
5. At any time you may specify:
   - Who you do not wish your information to be given to;
   - Or give restrictions on any content disclosure.

PRIVACY AND CONSENT FORM

Information Retention and Destruction

1. We will retain your personal information for the period necessary to continue providing services to you, and for its related administration.
2. We will destroy information in a secure manner when the information is no longer necessary for the provision of reflexology health services and is not required to be retained for compliance with provincial or federal regulations or statutes.

Access to your Records

1. I/We are committed to providing you with open access to your personal information.
2. You may at any time ask to see your records held and to request amendments to that information.
3. Access will be provided to you within a reasonable timeframe recognizing your desire for the information and our need to carry on our practice with limited interruption.

Contact

Should you have any questions comments or concerns, please bring them to our attention. We will be pleased to assist you.

Signature: _____ **Date:** _____