Awakened Soles Reflexology

Health, Happiness and Harmony

CONSENT TO TREAT & HEALTH FORM

Name: ______________________________________ Date of Birth: ______________________________________

Phone: (_____) ____________________________ Email Address: ____________________________________

Address: ____

City: __________________________ Province: ______________ Postal Code: _______________________________________

Doctor's Name: ____ Phone: (______) __________________________________

Emergency Contact Name: __________________________ _____ Phone: (______) __________________________________

How did you hear about me? : ____

GENERAL INFORMATION & MEDICAL HISTORY

Please take a moment to carefully read the following information and sign where indicated. If you have specific medical symptoms, reflexology may be contraindicated.

Occupation: ____

How much physical activity is included during work hours? (Sitting, Lifting, Walking?) ___________________________________

Do you exercise? ____________ How much time per day? ____________ Type of exercise? _____________________________

How do you feel about your health? ____

Have you ever experienced a professional reflexology session? _____________ How recently? _________________________

Yes	No	
Yes __________	No _____________	Do you suffer from anxiety or stress?
Yes __________	No _____________	Do you have diabetes? Epilepsy? Migraines? Phlebitis/Thrombos? If yes, please specify____
Yes __________	No _____________	Do you sleep well?
Yes __________	No _____________	Do you experience frequent headaches?
Yes __________	No _____________	Are you or could you be pregnant?
Yes __________	No _____________	Do you suffer from arthritis?
Yes __________	No _____________	Do you have any cardiac or circulatory problems?
Yes __________	No _____________	Do you have a pace maker?
Yes __________	No _____________	Do you have high blood pressure? Medication? ________________________
Yes __________	No _____________	Do you have allergies? If yes, how severe? ____________________________
Yes __________	No _____________	Have you suffered from any illnesses or injuries in the past 5 years? If yes, please specify____
Yes __________	No _____________	Have you had any surgeries? If yes, please specify____
Yes __________	No _____________	Do you have any tension or soreness in a specific area? If yes, please specify____
Yes __________	No _____________	Have you ever had heel spurs?
Yes __________	No _____________	Have you ever had plantar fasciitis?
Yes __________	No _____________	Do you have any warts or contagious diseases?

Is there any other medical condition or are you taking any medications I should know about?

____

If you answered yes to any of the above questions, please explain as clearly as possible to better assist the reflexologist.

I understand that the reflexology/foot massage or hand massage treatment I receive is provided for the basic purpose of relaxation. I acknowledge that the therapist has discussed the possible side effects and risks of this treatment and has provided me with such information as is pertinent. If I experience any pain or discomfort during my treatment I will immediately inform the reflexologist so that the pressure may be adjusted to my level of comfort. I further understand that reflexology should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any physical or mental ailment of which I am aware. If applicable and relevant, alternative courses of treatment may be explained to me. I understand that the reflexologist is not qualified to diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the treatment given should be construed as such. Because reflexology should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the reflexologist updated as to any changes in my medical profile and understand that there shall be no liability on the reflexologist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of my treatment, and I will be liable for payment of the scheduled appointment.

☐ I would like to receive emails for special promotions and spa days from Awakened Soles Reflexology.
(We keep your email private and do not share information with any third party)

Client Name: ______________________________ *(please print)*

Reflexologist Name: ______________________________ *(please print)*

Client Signature: __________________________

Reflexologist Signature: __________________________

Date: ____________________________________

Date: ____________________________________

CONSENT TO TREATMENT OF A MINOR

By my signature below, I hereby authorize Debra MacFadyen to administer a reflexology/foot massage or hand massage treatment on my child or dependent, as they deem necessary.

Date: _______________________________

Parent/Guardian: ____________________________ *(please print)*

Child/ Dependent: ____________________________ *(please print)*

Parent/Guardian Signature: ____

Reflexologist Signature: ____