RACHEL HOLDEN
Certified Reflexologist, H.C.A., P.S.W.

1761 Riverside Dr. E.,
Windsor, Ontario
N8Y 1A1
Phone #(519) 258-6278
Fax # Same

Name ---------------------------------- Date of Birth ----------------------------------
month day year

Address---
city province postal code

Telephone ----------------------- Business Phone --------------------------------

Occupation ---

What therapies have you tried before? When? -------------------------------------

Referred by? --

I understand that Rachel Holden services are designed to be a health aid and are in no way to take the place of doctor's care when it is indicated. Information exchanged during any session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to used at my own discretion.

I understand that Rachel Holden does not diagnose or treat illness or injures and that I am soley responsible for my physical and psychological wellness, and for seeking medical treatment when I feel it is neccessary for my well being. Rachel Holden shall not be held liable for choices that I make in this regard.

I give permission to Rachel Holden to do Reflexology.

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Date Your Signature

Reflexology Health Record

Note: This form to be completed on the **first visit only.**

Name: ____________________ Today's Date: ____________________ (Month/Day/Year)

Address: ____________________ Tel. Res: ( ) ____________________

Town: ____________________ Tel. Bus: ( ) ____________________

Prov./State: __________ PC/Zip: __________ Birth Date: ____________________ (Month/Day/Year)

Last Medical Visit: ____________________ Findings (Medical): ____________________

Have you had any accidents?	No ☐	Yes ☐	What/When?	______
Do you have any serious illness?	No ☐	Yes ☐	What/When?	______
Have you been hospitalized recently?	No ☐	Yes ☐	Why/When?	______
Have you had any broken bones?	No ☐	Yes ☐	What/When?	______
Have you had any surgery?	No ☐	Yes ☐	What/When?	______
Are you on medication?	No ☐	Yes ☐	What/Why?	______
Do you have any heart problems?	No ☐	Yes ☐	What/When?	______
Do you have a pacemaker?	No ☐	Yes ☐	Where/When?	______
How is your blood pressure?	Normal ☐	Not Normal ☐	Why?	______
Do you have any circulatory problems?	No ☐	Yes ☐	What?	______
Are you pregnant? (female only)	No ☐	Yes ☐	Trimester?	______
Any history of cancer?	No ☐	Yes ☐	What/When?	______
Do you have diabetes?	No ☐	Yes ☐	What/When?	______
Do you have epilepsy?	No ☐	Yes ☐	What/When?	______
Do you wear any prostheses? (artificial limbs, hearing aids, etc)	No ☐	Yes ☐	What/Where?	______
Do you smoke / have allergies?	No ☐	Yes ☐	What/When?	______
Are you taking other therapies?	No ☐	Yes ☐	What?	______
Have you had Reflexology before?	No ☐	Yes ☐	Who/When?	______

Who referred you to us? ____________________ What is your occupation? ____________________

Who is your doctor? ____________________ Doctor Tel. #: ____________________

Present Problems: ____________________

____

Consent for Reflexology Session:

I understand and accept that the sessions received are of therapeutic value only and fully accept responsibility for the same.

Signature: (parent/guardian) ____________________ Date: ____________________