Leg or Arm Pain / Numbness	Varicose Veins	High Blood Pressure
Blood Clots (Past/Present)	Pregnant	Low Blood Pressure
Leg Swelling	Warts	Diabetic
Fibromyalgia	Spinal Fusion	Other: _____

Treatment Consent

I understand that the treatment I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. I further understand that this treatment should not be construed as a substitute for medical examination, diagnosis and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

Because these treatments may be counter-indicated under certain conditions, I affirm that I have stated all my known medical conditions, and answered my questions honestly. I agree to keep the therapist updated 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: _____

Treatment Cancellation Policy

Cancellation policy is as follows: Patient must cancel a minimum of six (6) business hours in advance (after hours does not apply), send someone else in you place, or pay a late cancellation fee of $20.00 less than the treatment fee. If you arrive late you will receive the remainder of you booked appointment time. You will be required to pay for the time booked. Thank you for your co-operation and understanding.

Signature: _____ Date: _____

Confidential Client History

Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Birthdate: _____

Physician: _____ Email: _____

How did you hear about us? _____

Reason for today's massage/reflexology visit: _____

Has this issue been treated before? _____ If yes, how? _____

_____

Are you currently receiving any other type of treatment? _____

Please list any medications you are presently taking: _____

Please indicate if you have a nut allergy.	Yes	No
Have you had surgery in the past 10 years.	Yes	No
Have you ever been diagnosed with any type of cancer during the past 10 years?	Yes	No
Are you presently taking medication for a heart related problem?	Yes	No

Listed below are conditions that may seem unrelated to the purpose of you visit. Please review each carefully and circle those that you experience. These may relate to and / or affect your massage / reflexology treatment.

Headache	Lower Back Pain	Nausea / Vomiting
Dizziness	Hip Pain	Diarrhea
Constipation	Neck Pain / Stiffness	Persistent Cough
Asthma	Pain Between Shoulders	Depression
Jaw Pain / Clicking	Eczema	Spinal Curvature