

Reflexology Client Information



First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

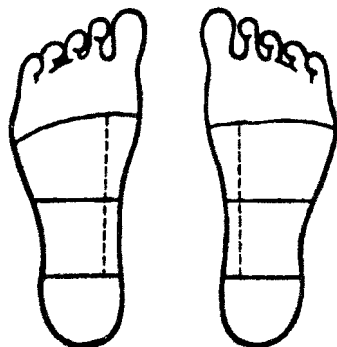
Home Phone _____ Work Phone _____ Cell _____

Birth date _____ Sex _____ Height _____ Marital Status M S W D

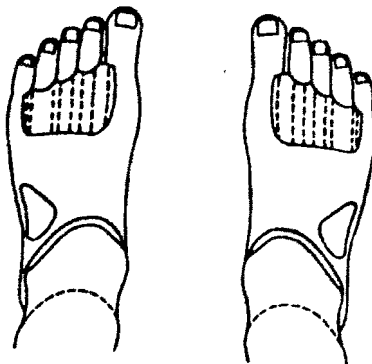
Who Referred you to us? _____

Please read & fill out the entire page 2 on the back of this document. Please Do NOT Write or draw on the Foot diagram below this line. ☺ Thank you.

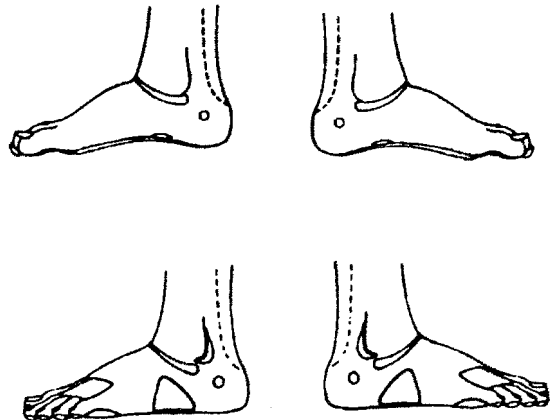
Right & Left Plantar



Left & Right Dorsal



Right & Left Medial



Left & Right Lateral

DATE	COMMENTS <i>Use additional sheets if needed.</i>

over →

Client Nutritional Statement & Health Information

1. Have you ever had or been diagnosed as having problems with any of the following:

- | | | | | |
|---------------------------------------|--------------------------------------|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Digestion | <input type="checkbox"/> Circulation | <input type="checkbox"/> Kidneys |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Stomach | <input type="checkbox"/> Prostate | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Nerves | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ovaries | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Throat | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Colon | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Breast | <input type="checkbox"/> Tumors | <input type="checkbox"/> Candida |
| <input type="checkbox"/> Spine/Back | <input type="checkbox"/> Bladder | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Weight | <input type="checkbox"/> Spleen |
| <input type="checkbox"/> Fibromyalgia | | | | |

2. Occupation _____ How Many years _____

3. Are you Allergic to any food / Medication? _____

4. Are you Pregnant? yes [] No []

5. Are you under a lot of stress? (Circle one) Home 1 2 3 4 5 6 7 8 9 10 Help!
Work 1 2 3 4 5 6 7 8 9 10 Help!
Health 1 2 3 4 5 6 7 8 9 10 Help!

6. What conditions are you presently under a Physicians care for? _____

7. List all Medications you are Currently taking? _____

Client Statement

I understand that I am here to learn about Reflexology, nutrition & better health practices. Reflexology is used primarily for: relieves stress and tension, supports nerve and blood supply, and helps the body to reach homeostasis (balance).

I will be offered information about food supplements & herbs as a guide to general good Health, and if I choose to use any information for my own personal advantage, that is my constitutional right.

I fully understand that those who counsel me are not Medical Doctors or practitioners And I am NOT here for Medical Diagnostic purposes or treatment procedures. I am not on This visit or any subsequent visits as an agent for federal, state or local agencies or on a Mission of entrapment or investigation. The services performed by Laura Potter are on the Subject of nutritional matters intended for the maintenance of the best possible state Of nutritional health, and DO NOT involve the diagnosing, treatment, or prescribing of Remedies for disease.

Signature _____ Date _____