Sage Naturopathic Clinic
Feel Better - We Can Help
230 East Ave. Suite 201, Kitchener, ON N2H1Z4 ☎ 519.573.6700 info@thesageclinic.com www.thesageclinic.com @thesageclinic

Reflexology Intake

Date: _____ Name:_____

Address:_____

_____

Phone No. _____ Email: _____

Date of Birth: _____

Past: (include approximate timing)

- Have you had any major illnesses? _____
- Major surgeries? _____
- Accidents or traumas? _____
- Injuries? _____

Present:

What are you doing to support your health?

- Other Therapies: _____
- Supplements: _____
- Medications: _____
- How is our diet and do you have any food restrictions? _____
- Do you sleep well? _____
- Do you exercise or are active? _____
- How much water do you drink in a day? _____
- Are you experiencing any current challenges? _____
- Do you have any allergies or skin conditions? _____
- Is there anything else you would like me to know about your health? _____
  _____

Emergency Contact Name _____ Phone_____

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CONSENT TO TREATMENT

I consent to Reflexology Treatment with the understanding that the sessions are for the purpose of stress reduction, improved circulation promoting the body's natural functioning and healing process.

I understand I may stop treatment at any time. I will also let my practitioner know of any preferences regarding the treatment, such as pressure or technique.

I understand the Practitioner does not diagnose, prescribe medication or treat for specific conditions.

I understand these records and what transpires in a reflexology session are kept confidential by the practitioner.

Signature_____ Date _____