

HEALTH QUESTIONNAIRE

What type of session
are you here today for?

Reflexology

Indian Head Massage

Reiki

Date _____

Name _____ Birthdate _____

Address _____

Phone Number _____ Work Number _____ Cell Number _____

Email Address _____ Occupation _____

Family Doctor _____ Phone Number _____

Please Check off if you have any of the following conditions and/or problems:

- | | | |
|---|--|---|
| Spine/Neck Pain..... <input type="checkbox"/> | Menopause..... <input type="checkbox"/> | Cold Hands & Feet..... <input type="checkbox"/> |
| Headaches/Migraines..... <input type="checkbox"/> | Prostate problems..... <input type="checkbox"/> | Blood Clots..... <input type="checkbox"/> |
| Neurological Issues..... <input type="checkbox"/> | Kidney or other..... <input type="checkbox"/> | AIDS/HIV..... <input type="checkbox"/> |
| Eyesight Issues..... <input type="checkbox"/> | Urinary Problems..... <input type="checkbox"/> | Hepatitis..... <input type="checkbox"/> |
| Hearing Issues..... <input type="checkbox"/> | Stomach Problems..... <input type="checkbox"/> | Glandular Problems..... <input type="checkbox"/> |
| Diabetes..... <input type="checkbox"/> | Ulcers..... <input type="checkbox"/> | Allergies..... <input type="checkbox"/> |
| Hypoglycemia..... <input type="checkbox"/> | Constipation..... <input type="checkbox"/> | Emotional/Psychological..... <input type="checkbox"/> |
| Asthma..... <input type="checkbox"/> | Diarrhea..... <input type="checkbox"/> | Weight Problems..... <input type="checkbox"/> |
| Skin Disorders..... <input type="checkbox"/> | Digestive Disorders..... <input type="checkbox"/> | Arthritis..... <input type="checkbox"/> |
| Pregnant..... <input type="checkbox"/> | High or Low Blood Pressure..... <input type="checkbox"/> | Cancer..... <input type="checkbox"/> |
| Difficulty Sleeping..... <input type="checkbox"/> | Heart Conditions..... <input type="checkbox"/> | Dental Problems..... <input type="checkbox"/> |
| Menstrual Problems..... <input type="checkbox"/> | Poor Circulation..... <input type="checkbox"/> | Other not mentioned..... <input type="checkbox"/> |

Are you currently being treated for any serious health condition? YES NO

Have you had surgery in the last 6 months? YES NO

Have you had any serious injuries in the last 6 months? YES NO

Do you have any existing foot conditions that you should mention? YES NO

Do you have any allergies to certain types of oils, latex, or scents? YES NO

Do you exercise regularly? YES NO

Do you smoke or inhale lots of second hand smoke? YES NO

How many glasses of water do you drink per day? _____

Are you doing any other therapy regularly to help your overall health? YES NO

If so, which ones? _____

Have you ever had a Reflexology, Indian Head Massage or Reiki Session in the past? YES NO

