KAWARTHACARE
Wellness Centre

282 Kent St. West, Lindsay, Ontario, K9V 2Z6
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Patient Intake Form Version 0714

Reflexology Health History

Identification:

◯ Mrs. ◯ Miss. ◯ Ms. ◯ Mr. ◯ Dr.

First Name _____ Initials _____ Occupation _____

Last Name _____ Employer _____

Date of birth *(DD/MM/YY)* _____ Height _____ Weight _____ Age _____

Contact information:

Street address _____ Home phone _____

City _____ Province _____ Cell phone _____

Postal Code _____ Work phone _____

Email _____ Call me first at: ◯ Home ◯ Cell ◯ Work

Emergency contact (Name) _____ Emergency phone _____

Family physician:

Name _____ Phone _____

Address _____

Do you have extended health care ?

☐ No ☐ Yes (check all that apply) : ◯ Acupuncture ◯ Chiropractic ◯ Compression Hosiery ◯ Massage Therapy ◯ Orthotics

	No	Yes	
Have you had any accidents?	☐	☐	What/when? _____
Do you have any serious illness?	☐	☐	Please list: _____
Recent hospitalization?	☐	☐	When/what? _____
Broken bones?	☐	☐	When/what? _____
Surgery in past 10 years?	☐	☐	Please list: _____
Do you take medication?	☐	☐	Please list: _____
History of heart problems?	☐	☐	Please list: _____
How is your blood pressure?	☐	☐	Please explain: _____
History of circulatory problems?	☐	☐	Please explain: _____
Are you pregnant?	☐	☐	Trimester? _____
History of cancer?	☐	☐	Please list: _____
Are you diabetic?	☐	☐	Type 1 or 2? _____
Are you epileptic?	☐	☐	
Do you smoke or have allergies?	☐	☐	Please list: _____
Are you involved in any other therapies?	☐	☐	Please list: _____
Have you had reflexology before?	☐	☐	When? _____

How did you find out about us? _____

If you were referred through another person, we would love to thank them! Please provide us with their name: _____

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

PRINT NAME _____ SIGNATURE _____