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 ________