Lucas & Lucas, LLC – Reflexology Intake Questionnaire

Thank-you for choosing Lucas & Lucas, LLC for your health care needs. We know you have a choice and are glad you have decided to put your confidence in our care. Please take a moment to fill out all of the following information as accurately and thoroughly as possible.

Name: ______________________________
Address: ______________________________
City/State/Zip: ______________________________
Emergency Contact Name: ______________________________
Emergency Contact Number: ______________________________
Emergency Contact Relationship: ______________________________

Date of Birth: ____________________ Age: ________
Primary Contact Number: Hm, Wk or Cell ____________________
Secondary Contact Number: Hm, Wk or Cell ____________________
E-Mail: ______________________________
Occupation: ______________________________
Referred By: ______________________________

Have you ever had a REFLEXOLOGY session? ☐ **YES** ☐ **NO**

Reason For Visit & Goals: ____

PLEASE CHECK THOSE THAT APPLY:

Special Conditions
- ☐ In Vitro Fertilization
- ☐ Pregnancy
- ☐ Cancer
- ☐ Plantar Warts
- ☐ Diarrhea
- ☐ Infections
- ☐ Blood Clots (*WHEN?*) _______
- ☐ Seizures

Genito-Urinary
- ☐ Urinary Tract Infections
- ☐ Frequent or Painful Urination
- ☐ Kidney Stones

Endocrine / Skin
- ☐ Thyroid: Hyper / Hypo
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Open Wounds or Lesions
- ☐ Skin Problems or Rashes
- ☐ Eczema / Psoriasis

Reproductive
- ☐ PMS
- ☐ Breast Sensitivity / Lumps
- ☐ Painful or Irregular Periods
- ☐ Endometriosis
- ☐ Pelvic Inflammatory Disease
- ☐ Ovarian Cyst/Uterine Fibroid
- ☐ Menopause
- ☐ Infertility
- ☐ Low Libido
- ☐ Other Issues:

____

Lymphatic / Immune
- ☐ Chronic Fatigue
- ☐ Rheumatoid Arthritis

Cardio-Vascular
- ☐ High or Low Blood Pressure
- ☐ Varicose Veins
- ☐ Heart Disease
- ☐ Cold Hands / Feet
- ☐ Swelling Hands / Feet

Gastro-Intestinal / Digestive
- ☐ Heart Burn / Acid Reflux
- ☐ Ulcer
- ☐ Indigestion
- ☐ Gallstones
- ☐ Constipation
- ☐ Irritable Bowel Syndrome

Neurological
- ☐ Stress
- ☐ Headaches (TYPE) __________
- ☐ Dizziness

Respiratory
- ☐ Allergies / Sinus / Congestion
- ☐ Asthma
- ☐ Bronchitis
- ☐ C.O.P.D.

Eyes
- ☐ Eye Pain / Blurred Vision
- ☐ Cataracts

Musculo-Skeletal (Please *briefly* note any Body or Joint Tension, Stiffness, Pain, etc.): ______________________________

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REFLEXOLOGY IS NOT A SUBSTITUTE FOR MEDICAL CARE.
IF YOU ARE EXPERIENCING ANY SPECIFIC MEDICAL PROBLEM AND HAVE NOT SEEN YOUR MEDICAL DOCTOR, I RECOMMEND YOU DO SO TODAY.

FOR THE FOLLOWING: *If "yes", please explain in the comments area of this form.*

☐ Yes ☐ No Have you ever had any broken bones or fractures?
☐ Yes ☐ No Have you ever had surgery?
☐ Yes ☐ No Have you ever had **any organs removed**? *(hysterectomy, appendix, tonsils, gallbladder, etc.)*
☐ Yes ☐ No Do you have any other medical condition I should be aware of?
☐ Yes ☐ No Do you take any medications?

Comments:____
____
____

LIFESTYLE

How is your diet?	☐ Good	☐ Average	☐ Poor	
How is your water intake?	☐ Good	☐ Average	☐ Poor	
How is your sleep?	☐ Good	☐ Average	☐ Poor	
How is your time in nature?	☐ Good	☐ Average	☐ Poor	
How is your exercise?	☐ Good	☐ Average	☐ Poor	Type of exercise: ______________________________
How is your relaxation?	☐ Good	☐ Average	☐ Poor	Type of relaxation:______________________________

Do you use or take:

Tobacco:	☐ Yes	☐ No	☐ In the past / For how long?__________	Type? __________	Frequency? : ______________
Alcohol/Drugs:	☐ Yes	☐ No	☐ In the past / For how long?__________	Type? __________	Frequency? : ______________
Caffeine/Soft Drinks:	☐ Yes	☐ No	☐ In the past / For how long? ______________________________		

Informed Consent to Treatment

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED

Reflexology utilizes the unique application of thumb, finger and hand pressure in order to engage specific points on the feet. This can result in stress reduction and relaxation which may cause physiological changes in the body.

If you have a specific medical condition or specific symptoms, reflexology may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

By signing this form, I give my consent to a reflexology session. I also acknowledge I have read and understand the information below:

- I affirm that that the above health history information is correct to the best of my knowledge and I agree to keep the Reflexologist updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I neglect to do so.

- I further understand that reflexology should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. A Reflexologist is not a medical doctor and does not prescribe or adjust medication.

- I understand that I may experience some uncomfortable physiological responses that are sometimes related to the self healing process such as: nausea, dizziness, diarrhea, or muscle soreness - all of which may occur naturally.

- I understand that this is a professional reflexology session and is in no way sexual in nature. If the practitioner feels that **any** inappropriate illicit or sexually suggestive gestures, remarks or advances are made by me, this will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

- I understand that **once I have scheduled an appointment, all other patients and clients are denied that block of time**. I may be charged the full fee for my session, if I do not provide notice of cancellation within 24 hours of the scheduled visit.

Client Signature: ______________________________________ Date: ________________