moxiemind&body pilates studio

Holistic Reflexology Client Intake

Please print clearly. This information is critical for your Pilates session(s), as it may affect the structure and focus of your session. All information disclosed will be kept strictly confidential.

YOUR INFORMATION

First and Last Name: ______________________________

Email: ______________________________

Phone: ______________________________

Address: ______________________________

____

____

Date of Birth: ______________________________

Gender: ______________________________

Pronouns: ______________________________

Occupation: ______________________________

Marital Status: ______________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ______________________________

Emergency Contact Email: ______________________________

Emergency Contact Phone: ______________________________

Emergency Contact Relationship to You: ______________________________

Holistic Reflexology Medical Questionnaire

Height: ______________________ Weight: ______________________

Blood Pressure: ____

Have you gained or lost a significant amount of weight in the past 6 months?

____

Have you ever been treated with holistic medicine? If yes, when and what type of treatment did you receive?

____

Have you ever had surgery? If yes, when and what type of surgery?

____

____

Do you still suffer from any problems associated with the condition that the surgery was meant to correct?

____

____

____

Are you currently taking any medications? If yes, what are you taking the medication for? What is the amount of dose and how often do you take it?

How many bowel movements do you have per day?

How many times do you urinate?

How many hours do you sleep each night?

How would you describe your sleep patterns? (Do you sleep the whole night through? Do you wake up during the night? Do you have nightmares?)

Are there noises in your environment that might disturb your sleep?

Do you remember your dreams?

Do you exercise? How often and what type of exercise?

NUTRITIONAL HEALTH

How many regular meals do you eat per day?

How would you describe the composition of your diet?

What times do you normally eat?

EMOTIONAL HEALTH

How do you express your anger?

How do you express your happiness?

Is there a history of family illness? (diabetes, blood pressure, osteoporosis, cancer, heart disease, etc.)

For which reason do you seek to be treated with Holistic Reflexology?

YES/NO QUESTIONS **YES | NO**

For your safety, I must be aware of all medical conditions for which you have been diagnosed. Are you aware of...

	YES	NO
Sensitivity to medication:	☐	☐
Allergies:	☐	☐
Migraines and Headaches:	☐	☐
Irregular heartbeats:	☐	☐
Periods of high and low energy:	☐	☐
Fainting spells:	☐	☐
Dizziness:	☐	☐
Digestive problems:	☐	☐
Ulcers:	☐	☐
Bad breath:	☐	☐
Gum disease:	☐	☐
Respiratory problems:	☐	☐
Vision disorders:	☐	☐
Hearing disorders:	☐	☐
Bone or joint disorders:	☐	☐
Spinal problems:	☐	☐
Problems with taste or smell:	☐	☐
Virus infections:	☐	☐
Skin disease:	☐	☐
Eczema or fungal infections:	☐	☐
High fever:	☐	☐

YES/NO QUESTIONS

For your safety, I must be aware of all medical conditions for which you have been diagnosed. Are you aware of...

	YES	NO
Heart Disease:	☐	☐
Diabetes:	☐	☐
High blood pressure:	☐	☐
Varicose Veins:	☐	☐
Cancer:	☐	☐
Osteoporosis:	☐	☐
Organ transplants:	☐	☐
Heart pacemaker:	☐	☐
Metal implants:	☐	☐
Epilepsy:	☐	☐
Mental Health diagnoses:	☐	☐
HIV/AIDS:	☐	☐
Kidney problems:	☐	☐
Hepatitis:	☐	☐
Tuberculosis:	☐	☐
Leg/foot cramps:	☐	☐

Please indicate if you currently have any of the following conditions:

Any Areas of infection?

Any areas of swelling, edema or tendency to swell?

Any areas of numbness or abnormal sensation?

Any areas of pain or tenderness?

Other Medical Conditions?

Do you currently use alcohol, tobacco or drugs? If yes how often?

COVID-19

Are you currently experiencing symptoms that could be related to Covid-19, e.g. fever or chills, cough, fatigue, difficulty breathing, body aches, headache, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?

Were you diagnosed with Covid-19 in the past?

When?

Which treatment was given?

Did you receive the Covid-19 vaccine?

If so, when?

Number of pregnancies:

Number of births:

Are you pregnant now?

Do you experience menstrual cycles?

For how many days do you menstruate and how long is your menstrual cycle?

Do you experience PMS?

Do you experience mental or emotional changes before or during your menstruation?

Please take a moment to read and initial the following information:

________ I understand that Reflexology should not be used as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of.

________ I affirm that I have stated all my known medical conditions, and answered all questions honestly. I have not withheld any important information concerning my health condition. I agree to keep the Holistic Reflexologist, Aubrey Johnson, updated as to any changes in my medical profile and understand that there shall be no liability on the Holistic Reflexologist's part.

________ Should I need to cancel future sessions, I agree to give my practitioner 24 hours notice or I will be financially responsible for the session time.

________ If I experience pain or discomfort during the session, I will immediately inform the Holistic Reflexologist so that pressure/strokes can be adjusted to my level of comfort. I will not hold Holistic Reflexologist responsible for any pain or discomfort I experience during or after the session.

________ I affirm that I have notified the Holistic Reflexologist of all known medical conditions and injuries.

________ I agree to inform the Holistic Reflexologist of any changes in my health and medical condition. I understand that there shall be no liability on the Holistic Reflexologist part should I forget to do so.

Please take a moment to read and initial the following information:

________ By signing this release, I hereby waive and release my Holistic Reflexologist, Aubrey Johnson, from any and all liability, past, present, and future relating to Holistic Reflexology.

________ I have received the policy statement, and have read and agree to the policies therein.

______________________________________ ______________________

Signature Date

______________________________________ ______________________

Holistic Reflexologist Signature Date