Indian Head Massage Questionnaire

Please complete this form so that I may obtain a clear indication of your current condition.

Name: _____ **Date of birth:** _____

Street address: _____ **City:** _____

Postal Code: _____ **Email:** _____

Cell phone no: _____ **Doctor's name:** _____

What is your occupation? _____

Who referred you? _____

Do you have?

Any resent head or neck injury, including whiplash or concussion?	❑ Yes	❑ No
Severe bruising in the head and neck areas to be treated?	❑ Yes	❑ No
Infectious skin and scalp disorders?	❑ Yes	❑ No
Cuts and abrasions in the treatment area?	❑ Yes	❑ No
Recent operation?	❑ Yes	❑ No
High temperature, illness, or fever?	❑ Yes	❑ No
Osteoporosis?	❑ Yes	❑ No
Cancer or any other serious condition, which is: _____	❑ Yes	❑ No

Is there anything else I should know about your health? _____

_____

Consent to Receive Treatment:

I, the undersigned, consent to reflexology treatment and understand that sessions are for the purpose of stress reduction and relaxation. I may stop the session at any time, either during the assessment or the treatment. Reflexology Therapists do not diagnose, prescribe medication for medical or psychological conditions, nor treat for specific conditions. I understand that the treatment should not be construed as a substitute for medical examination, diagnosis or treatment and that I should consult a physician or other qualified medical specialist for mental or physical ailments that I am aware of.

Your name (please print): _____

Your signature: _____

Today's date: _____