Client Record: Detoxification

Please complete this form. This information is critical to your session(s) as it may affect the focus and outcome of it. All information disclosed will be kept for session purposes only and in strict confidentiality.

Name_____Date_____Therapist_____

	Yes	No
Have you ever received a reflexology treatment? When? _____	☐	☐
Is there anything specific you are hoping to be treated with reflexology today?	☐	☐
If so, please explain _____		
Have you (ever) been diagnosed with Deep Vein Thrombosis or a history of blood clots?	☐	☐
If so, please explain _____		
Are you now, or have you ever been on blood thinners? When? _____	☐	☐
Please answer the following 4 questions only if you are receiving ear candling.		
Have you ever received an ear candling treatment? When? _____	☐	☐
Do you have, or have you ever had a perforated ear drum?	☐	☐
Have you ever had tubes placed in your ears?	☐	☐
Ear oil helps decrease infections, fungus and bacteria. Do you agree to the placement of this oil in your ear canal after your candling session?	☐	☐

List any current medications, including any over the counter drugs: _____

_____

Please mark the correct box for any conditions that you currently have, or have had in the past:

☐ Allergies	☐ Cancer	☐ Headaches/Migraines	☐ Hip/Leg Pain	☐ Rashes
☐ Athletes Foot	☐ Corns	☐ Heart Condition	☐ Lupus	☐ Sinus Surgeries
☐ Blood Clots	☐ Depression	☐ High Blood Pressure	☐ Muscle Spasms	☐ Sleep Disorder
☐ Bone/Joint Disease	☐ Diabetes	☐ HIV/AIDS	☐ Numbness/Tingling	☐ Stiffness
☐ Bone/Joint Injury	☐ Diverticulitis	☐ Ingrown Toenail	☐ Painful Feet/Swelling	☐ Tendonitis
☐ Bunions	☐ Fibromyalgia	☐ IBS	☐ PMS	☐ Vertigo
☐ Bursitis	☐ Hammer Toes	☐ Lower Back Pain	☐ Pregnant? #wks___	☐ Warts

***NOTE if you have a pacemaker or are pregnant you are ineligible for a Bio-Detox Foot Cleansing Treatment.**

****If you experience any pain during the session(s), please immediately inform the therapist, so that the work can be adjusted to your level of comfort.**

By signing below, I state that all of the information on this form is accurate. I understand that the services I receive are for the basic purpose of relaxation, stress reduction and relief of muscular tension and that massage/bodywork should not be a substitute for medical examination, diagnosis, or treatment. If receiving ear candling, I realize the service is being given for the well-being of my body (including clearing wax, evaporating water, or clearing my sinuses.) There can be risks associated with this treatment due to wax dripping, etc. I agree to keep the spa updated as to any changes to my medical profile. I understand there will be no liability on the spa or the therapist's part in proceeding with these treatments.

Please indicate if signing for a child. Yes☐ No☐

Signature_____ Date_____