Babies & Bellies 3D/4D Ultrasound Studio

and Prenatal Wellness Spa

Client Intake Form – Reflexology & Reiki with Erika Lucas

Name:_______________________________________ Date of Birth:___________ Sex:_____

Address:____

Phone:_____________________ Occupation:______________________________________

Referred by:____

Current Health Concerns:____

____

What would you like from today's session?_______________________________________

____

Where do you hold tension in your body?____

Posture you assume most of the day (sitting, walking, standing, etc.):_____________________

What is the major complaint or condition you want to improve?__________________________

____

What improves this condition?____

What have you done to address this condition?_____________________________________

Are you currently under medical care and/or receiving treatment? If yes, why?______________

____

Please list all medications and/or supplements you are taking and why:____________________

____

Please list any allergies you have:____

Please list any previous surgeries:____

____

Please continue to page 2

Health History – Please check all that apply

Musculoskeletal	Circulatory & Respiratory	Reproductive
○ Headaches/Migraines	○ Dizziness/Fainting	○ Trying to become pregnant
○ Joint stiffness/swelling	○ Shortness of breath	○ Currently pregnant Weeks along:___________ Due date:______________ Any complications or risk factors?________________ ______________________
○ Spasms/cramps	○ Cold feet or hands	○ Other:______________
○ Broken/fractured bones	○ Cold sweats	**Other**
○ Back/Hip pain	○ Swollen ankles	○ Loss of appetite
○ Shoulder/Neck/Arm pain	○ Varicose veins	○ Depression
○ Hand pain	○ Blood clots	○ Difficulty concentrating
○ Leg/Foot Pain	○ Stroke	○ Drug use
○ Chest/Rib/Abdominal pain	○ Heart condition	○ Alcohol use____________
○ Problems walking	○ Allergies	○ Nicotine use____________
○ Jaw pain/TMJ	○ Sinus problems	○ Caffeine use____________
○ Tendonitis	○ Asthma	○ Diabetes
○ Bursitis	○ High/Low BP	○ Fibromyalgia
○ Arthritis	○ Lymphedema	○ Post Polio Syndrome
○ Osteoporosis	○ Other:_____________	○ Cancer______________
○ Scoliosis	**Nervous System**	○ Infectious Disease_______ ______________________
○ Bone or joint disease	○ Numbness/Tingling	○ Other:______________
○ Other:_____________	○ Fatigue	
Skin	○ Chronic pain	
○ Rashes	○ Sleep disorders	
○ Allergies	○ Paralysis	
○ Athlete's foot	○ Cerebral Palsy	
○ Warts	○ Seizure Disorder	
Digestive	○ Chronic Fatigue Syndrome	
○ Constipation	○ Multiple Sclerosis	
○ Irritable Bowel Syndrome	○ Muscular Dystrophy	
○ Crohn's Disease	○ Parkinson's Disease	
○ Colitis	○ Spinal Cord Injury	
○ Other:______________	○ Other:_____________	

Consent for Care

Holistic, complimentary therapies should not replace or interfere with the care of a physician. I understand that it is my responsibility to consult my physician prior to a Reflexology and/or Reiki session. I acknowledge the treatment that I am receiving is not a substitute for medical examinations or medical care and that it is recommended that I am concurrently working with my primary caregiver for any conditions I have. I understand the practitioner will not diagnose conditions or prescribe medications. I affirm that I have stated all known medical conditions and answered all questions to the best of my knowledge. I agree to keep the practitioner updated as to any changes in my conditions. By signing this form I give my consent to a Reflexology session.

Signature:____ Date:__________________

Signature of Parent/Guardian if under 18 years of age:____________________________ Date:________