

Statera Therapies

Confidential Health History

All answers given will aid in receiving the best possible treatment. Please fill out as honest and as in depth as you can. All information is considered confidential.

NAME: _____

ADDRESS: _____

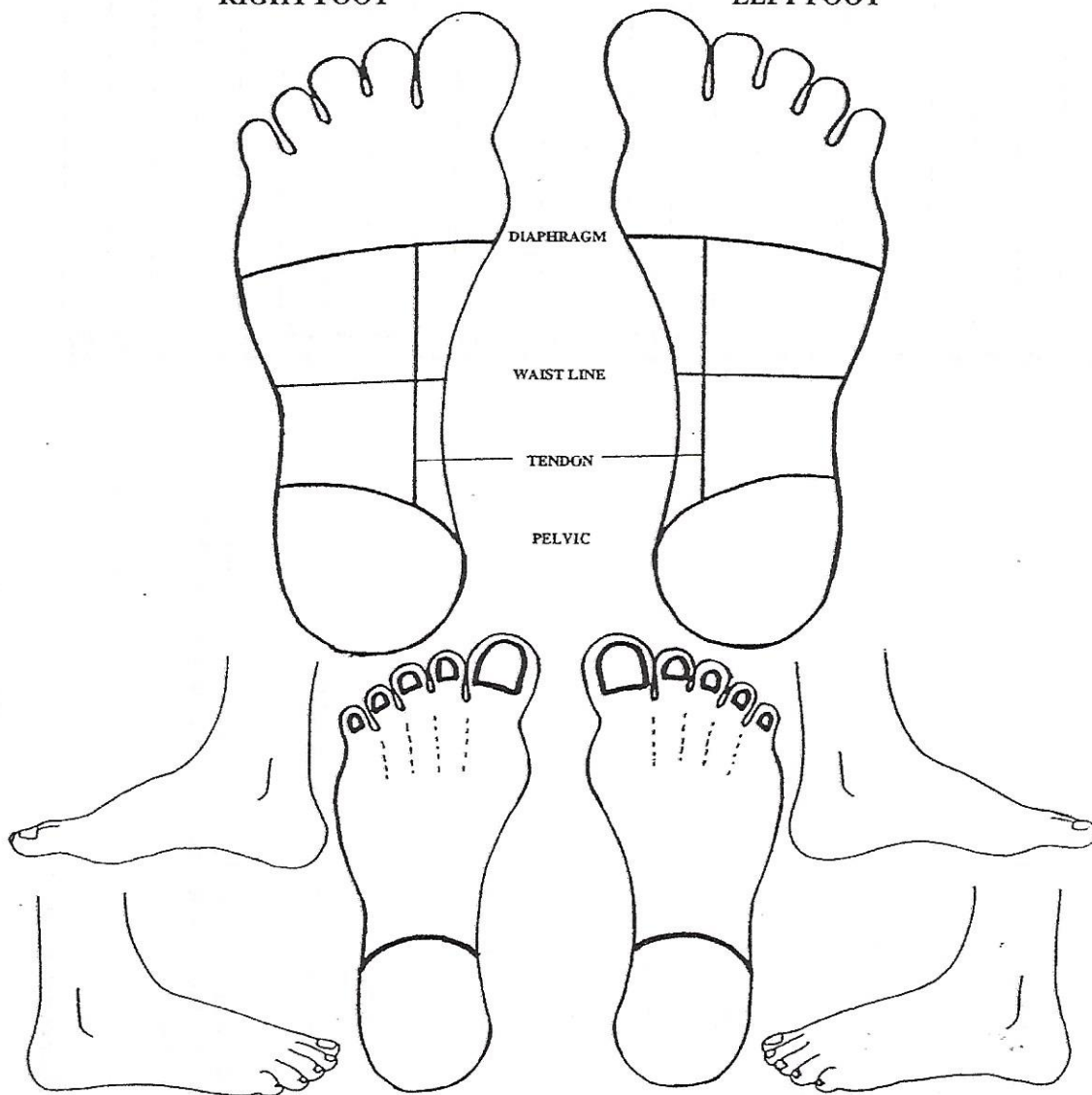
CITY or TOWN: _____

POSTAL CODE: _____ PHONE: _____

REFERRED BY: _____

RIGHT FOOT

LEFT FOOT



REFLEXOLOGY HEALTH RECORD

1. HOW ARE YOU FEELING?
2. WHAT ARE YOU DOING FOR YOUR HEALTH?
(i.e. exercise, vitamins etc.)
3. ARE YOU HAVING ANY OTHER THERAPIES?
4. ARE YOU UNDER A DOCTOR'S CARE FOR ANY REASON?

WHEN DID YOU LAST VISIT YOUR DOCTOR?

WHAT DID HE/SHE FIND?
5. HAVE YOU HAD ANY SURGERIES?
6. ARE YOU TAKING ANY MEDICATIONS?
7. HAVE YOU EVER HAD ANY ACCIDENTS?
(i.e. whiplash, broken bones etc...)
8. HAVE YOU EVER HAD ANY SERIOUS ILLNESS?
9. DO YOU SLEEP WELL?
10. HOW IS YOUR BLOOD PRESSURE?
11. IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL ME ABOUT YOUR HEALTH?

WE ARE NOT DOCTORS! WE WILL NOT DIAGNOSE, PRESCRIBE FOR, OR TREAT ANY SPECIFIC ILLNESS. IF YOU HAVE A MEDICAL PROBLEM, WE URGE YOU TO SEEK PROFESSIONAL MEDICAL HELP.

WE ARE WORKING ON _____
AT HIS/HER REQUEST.

I HAVE READ, AND UNDERSTAND THE ABOVE.

SIGNED _____ DATE _____

TREATMENT RECORD

1. _____
2. _____
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