

**HEAL TO TOE
REFLEXOLOGY
DOCUMENTATION FORM**

NAME _____ BIRTHDAY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE - - _____ WORK - - _____

NEAREST RELATIVE _____ PHONE - - _____

ALL SURGERIES (INCLUDING FEET) _____

PRESCRIPTION MEDICATION _____

NON-PRESCRIPTION MEDICATION _____

VITAMINS/MINERAL/HERBS _____

SYMPTOMS _____

BLOOD PRESSURE: HIGH _____ NORMAL _____ LOW _____

FAMILY PHYSICIAN _____ PHONE - - _____

OCCUPATION _____ DAILY WATER INTAKE _____

DIABETES _____ VARICOSE VEINS _____ KIDNEY STONES _____ MENSTRUATION _____

PREGNANT _____ DEPRESSION _____ AIDS _____

REFERAL _____

DATE _____ SIGNATURE _____