

PITT MEADOWS WELLNESS CENTRE



...experience life!

THERAPEUTIC REFLEXOLOGY / SHIATSU CARE

NAME _____

Date of Birth _____ () M F
Month / Day / Year Age

Address _____

City _____ Postal Code _____

Phone (Res) _____ Phone (Work) _____

Occupation _____

e-mail address _____

Whom may I thank for referring you? _____

Have you ever experienced Reflexology/Shiatsu Care? _____

If yes, when and how frequent? _____

Are you presently under medical care for a specific condition? _____

Do you have any conditions that you consider chronic? _____

If yes, when did you first notice the symptoms? _____

Are you on any medications at this time? If YES please specify: _____

PLEASE INDICATE IF THERE IS A FAMILY HISTORY OF ANY OF THE FOLLOWING:

- Heart Condition _____
- Cancer _____
- Diabetes Insulin Diet _____
- Arthritis _____
- Depression _____

Signature _____ **Date** _____

The work/therapy described above is meant to compliment and integrate traditional approaches to health care. It is not intended as a replacement for professional medical/health attention.