

Health or Trade Show Health Record & Waiver

Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Telephone: _____ E-mail: _____

Do you have (please circle one):

- | | | |
|----------------------------------|-----|----|
| a) Diabetes | YES | NO |
| b) Heart Disease | YES | NO |
| c) High Cholesterol | YES | NO |
| d) Blood Pressure Irregularities | YES | NO |
| e) Blood Clots | YES | NO |
| f) Foot/Hand/Ear Condition | YES | NO |

Have you ever had (please circle one):

- | | | |
|-----------------|-----|----|
| a) Stroke | YES | NO |
| b) Cancer | YES | NO |
| c) Heart Attack | YES | NO |
| d) HIV/Aids | YES | NO |
| e) Hepatitis | YES | NO |

Are you pregnant? Yes No If yes, how many months? _____

Anything else the therapist should know about your health?

Waiver

I understand that the treatment I receive is provided for the basic purpose of demonstrating the techniques and efficacy of Reflexology. Reflexology Therapist do not diagnose, prescribe medication for medical or psychological conditions, nor treat for specific conditions. I further understand that the treatment should not be construed as a full reflexology treatment or substitute for medical examination, diagnosis, or treatment and that I should consult a physician, or other qualified medical specialist for mental or physical ailments that I am aware of.

Because Reflexology is contraindicated under certain conditions, I confirm that I have informed the therapist of all my known medical conditions and answered any questions honestly. Should I seek further Reflexology treatment from the therapist I agree to update them as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Signature _____

Date _____

