NEW CLIENT INFORMATION

Date: _____ Service: ☐ Zone Therapy ☐ Massage

Name: _____ DOB: _____ Phone: _____

Address: _____

Email: _____

Chemotherapy? Y / N

Pregnant? Y / N

Supplements / Medications taken: NONE

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Surgeries/Implants (including pacemakers or IUD's)

_____

I understand that foot zone practitioners do not practice medicine, do not diagnose or treat for a specific illness and do not prescribe medication. I understand that foot zone technique is not a substitute for medical treatment but compliments most therapies. I understand that I should inform my doctor of receiving foot zones, if I have a condition that requires monitoring. I take responsibility for my own medical decisions and hold my foot zone therapist harmless regarding my decisions. Foot zone balance is a precise physical balance applied via direct pressure to the various 'zones' of the feet. The zone balance practitioner manipulates the foot and interprets the 'messages' it conveys through discoloration, spots, inflammation and tenderness. I understand this can start a cleansing process within my body and that I need to increase my water to assist my body and avoid feeling ill. I sign this form giving my consent to receive a foot zone Comfort Zone Therapy.

_____ _____

Signature Date