

Alist Wellness Center LLC

2333 Morris Ave. B 208, Union NJ 07083

www.alistwellnesscenter.com / tsila@alistwellnesscenter.com / 973-912-4448

REFLEXOLOGY CLIENT REGISTRATION INFORMATION

In order to serve you properly, we will need the following information. (Please print)

Last name: _____ First name: _____ MI _____ M / F _____ Date Birth: _____

Address: _____ City: _____ State: _____ Zip _____

Home phone: _____ Cell phone: _____ Email: _____

Employer _____ Your occupation: _____ Work phone: _____

PHYSICAL HISTORY: _____

PRESENT ILLMENTS: _____

OPERATIONS / INJURIES: _____

ARE YOU PRESENTLY UNDER DOCTOR'S CARE? IF SO PLEASE EXPLAIN: _____

WHAT MEDICATION(S) ARE OU PRESENTLY TAKING: _____

ARE YOU RECEIVING ANY THERAPY? IF SO PLEASE EXPLAIN: _____

HAVE YOU EVER RECEIVED REFLEXOLOGY SESSIONS IN THE PAST? IF SO, WITH WHOME: _____

HOW DID YOU LEARN ABOUT US: _____

I realize that a Reflexologist is not a Doctor, and cannot prescribe, diagnose, or treat for a specific condition. Reflexology relieves tension which in turn helps to improve nerve and blood supply and to normalize the body.

DATE: _____ SIGNATURE: _____

ALIST WELLNESS CENTER LLC

2333 Morris Ave. B-208 Union NJ 08083

www.alistwellnesscenter.com / tsila@alistwellnesscenter.com / 973-912-4448

CLIENT REGISTRATION INFORMATION

In order to serve you properly, we will need the following information. (Please print)

Last name: _____ First name: _____ MI _____ M / F _____ Date Birth: _____

Address: _____ City: _____ State: _____ Zip _____

Home phone: _____ Cell phone: _____ Email: _____

Employer _____ Your occupation: _____ Work phone: _____

EMERGENCY CONTACT INFORMATION

Name of person: _____ Relationship _____ Cell Phone: _____

Address: _____ City: _____ Zip: _____

CLIENT REFERRAL INFORMATION

Referred by: _____ If referred by a friend, may we thank her or him? Yes _____ No _____

Doctor _____ Referral _____ Website _____ TV _____ Google _____ Yahoo _____ Other _____ FB _____

Doctor's Name: _____ Phone: _____

Cancellation Policy: Cancellations or changes to scheduled appointments must be made 24 hours in advances of the scheduled appointment. Otherwise, you will be billed for the cost of service as a cancellation charge. Any check returned for insufficient funds will be subject to a \$35.00 processing fee.

If you calling after business hours, please leave a message on our voicemail indicating your appointment cancellation. The same charge applies for missing appointment

Name: _____ Signature: _____ Date: _____