

The Sole Connection, LLC

Client Intake Form

Name: _____ Date: _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____ Date of Birth: _____ Married _____ Single _____

Occupation: _____

Have you experienced reflexology before? _____

Who may we thank for referring you? _____

How would you rate your health? ___ Excellent ___ Good ___ Fair ___ Poor

When was your last visit to your doctor, chiropractor or medical practitioner?

Are you under a doctor's care? ___ Yes ___ No

If yes, please list the medication(s)/supplements and what they are used for:

Have you experienced any recent health problems? ___ Yes ___ No

If yes, please list:

Please list any surgeries, injuries, or serious /chronic illness (e.g. diabetes, heart problems, high blood pressure, etc.)

Have you had any foot injuries? ___ Yes ___ No

Are you pregnant? ___ Yes ___ No If yes, due date: _____

What are your stresses, if any?

Where do you hold your tension?

Describe your eating habits:

Do you have any allergies? If yes, please list:

Circle the best description for you in each category:

Blood pressure: High Normal Low

Headaches: Never Occasionally Reoccurring

Energy: High Normal Low

Mindfulness: Never forgetful Sometimes forgetful

Stress Level: High Normal Low

Digestive: No problems Occasional issues Constant issues

Bowels: No problems Occasional issues Constant issues

Sleep Pattern: Sleep well Occasional issues Constant insomnia

Exercise: Regularly Sometimes Never

If you exercise, what and how often?

Mark any of the following items that you have on your body or feet:

Athlete's foot Soreness/Tenderness Rash Scars/past injury Claw toe
 Swelling Varicose veins Dry, Flaky skin Broken bones Bunion Corns Callouses
 Plantar wart Current bruises Current injuries Hammertoe Soreness/tenderness
Nail Fungus Neuroma Sensitivity Other

Are you receiving any adjunct therapies? Yes No

If yes, please list: _____

What are your goals for seeking reflexology at this time?

Relaxation Stress relief Pain relief Other _____

Additional comments: _____

INFORMED CONSENT:

I give my informed consent to a reflexology session. I understand that I may discontinue the session at any time. If I have been diagnosed with a disease or condition, I understand that I should notify my doctor, or other licensed healthcare professional prior to my reflexology session. I understand that reflexology is not a substitute for medical care, medications, or any other prescribed medical modalities.

I understand that reflexologists do not diagnosis, prescribe, or offer medical advice, and nothing in the course of the session should be misconstrued as such. I understand that it is recommended that I speak to my doctor about specific medical issues.

Signature _____

Date _____

Printed name _____