



**Soul to Soul, LLC**  
Client Intake Form

**Please Print**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_

In Case of  
Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Relationship of Contact \_\_\_\_\_

**General and Medical Information:**

*Please check all that apply and clearly provide the details in space provided.*

\_\_\_ Are you pregnant \_\_\_\_\_

\_\_\_ Previous Injuries or Surgeries: \_\_\_\_\_

\_\_\_ Muscular issues or disease: \_\_\_\_\_

\_\_\_ Bone disorders or disease: \_\_\_\_\_

\_\_\_ Headaches: Frequency/Type /Severity \_\_\_\_\_

\_\_\_ Soreness or tension in any particular area: \_\_\_\_\_

\_\_\_ Skin rashes, athletes foot, warts \_\_\_\_\_

\_\_\_ Cardiac or circulatory issues, varicose veins, blood clots: \_\_\_\_\_

\_\_\_ High or low blood pressure: \_\_\_\_\_

\_\_\_ Pulmonary/Breathing-related issues: \_\_\_\_\_

\_\_\_ Diabetes: \_\_\_\_\_

\_\_\_ Seizures: \_\_\_\_\_

\_\_\_ Allergies/Please list: \_\_\_\_\_

\_\_\_ Auto Immune Disorders: \_\_\_\_\_

Please check all that apply and clearly provide the details in space provided.

\_\_\_ Swelling /edema: \_\_\_\_\_

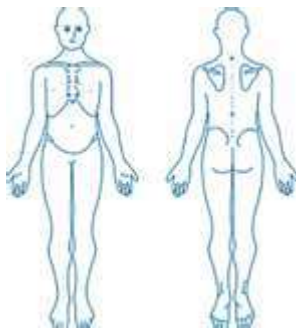
\_\_\_ Are you currently taking medication? Please list: \_\_\_\_\_

\_\_\_ Are you receiving any treatment for any condition, including chiropractic care, nervous disorders, or cancer: \_\_\_\_\_

\_\_\_ Do you have any illness, condition or health issues not identified above? Provide details \_\_\_\_\_

\_\_\_ Do you experience stress? On a level of 1 – 10, with 10 being severe, please indicate stress level \_\_\_\_\_

\_\_\_ Are there any areas on your body you wish the therapist to avoid? (Please circle areas on illustrations below)



**Please read the following statements and sign where indicated. If you do not understand any of the questions, please bring this to your therapist’s attention**

If you have a specific medical condition, illness or specific symptoms, we may require a referral from primary physician before service is provided. I understand that the body/energy work I receive is for the basic purpose of relaxation and/or relief of muscular tension. I further understand that the body/energy work I receive is not a substitution for medical treatment, examination, or diagnosis from a licensed physician and that Soul to Soul therapists/practitioners are not qualified to diagnose, prescribe or treat any physical, emotional or mental illness, and that nothing said during a session should be construed as such. I affirm that the information provided above is true and correct, and that I have honestly stated all my known medical information. Additionally, I understand and agree that there shall be no liability to the therapist and/or Soul to Soul, LLC, should I neglect to do so. I acknowledge Soul to Soul is a small business that maintains a 72 hr cancellation policy. Failure to cancel appointments within 72 hrs of appointment time and no-shows will be billed at full rate. By signing this form you give Soul to Soul your permission to charge your credit card on file the full amount for the missed appointment. \*Please note we do not take insurance or process any insurance paperwork on your behalf – it is your responsibility to download confirmations of appointments received as well as provide proof of payment to your insurance company. Further, we do not testify on behalf of any client in a court of law.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Yes, I’d like to receive your monthly Newsletter with specials, discounts and classes** \_\_\_\_\_