ANGEL'S TOUCH SF — CLIENT INTAKE FORM

www.angelstouchsf.com | San Francisco, CA

CLIENT INFORMATION

Full Name: _____ Date: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred by: _____ Primary Physician: _____

REASON FOR VISIT / AREAS OF CONCERN

Primary concern: _____

Secondary concern: _____

Current medications/supplements: _____

Allergies (including skin): _____

Have you had professional massage before? ☐ Yes ☐ No If yes, how often? _____

PLEASE CHECK ANY CONDITIONS YOU HAVE OR HAVE HAD PREVIOUSLY

RESPIRATORY:

- ☐ BREATHING DIFFICULTY
- ☐ EMPHYSEMA
- ☐ ALLERGIES _____
- ☐ SINUS PROBLEMS
- ☐ ASTHMA

SKIN:

- ☐ ALLERGIES
- ☐ RASH
- ☐ ATHLETES FOOT/FUNGAL INFECTION
- ☐ BACTERIAL SKIN INFECTION
- ☐ HERPES/COLD SORES
- ☐ SCABIES/PARASITIC INFECTION

NERVOUS SYSTEM:

- ☐ SHINGLES
- ☐ NUMBNESS
- ☐ TINGLING
- ☐ PINCHED/IMPINGED NERVE
- ☐ EPILEPSY

DIGESTIVE:

- ☐ IRRITABLE BOWEL SYNDROME
- ☐ ULCERS
- ☐ OTHER: _____

REPRODUCTIVE:

- ☐ PREGNANT: First, second, or third trimester?
- ☐ OVARIAN/MENSTRUAL PROBLEMS
- ☐ PROSTATE
- ☐ OTHER: _____

OTHER:

- ☐ CANCER/TUMORS
- ☐ BLADDER/KIDNEY AILMENT
- ☐ DIABETES
- ☐ CHRONIC FATIGUE
- ☐ CHRONIC PAIN

CHEMICAL:

- ☐ MEDICAL/RECREATIONAL CANNABIS
- ☐ ALCOHOL (if more than 1 drink per day)
- ☐ TOBACCO
- ☐ CAFFEINE: MILD / MODERATE / HEAVY (circle one)

ACKNOWLEDGEMENT:

I, the undersigned, acknowledge that I have completed this form to the best of my knowledge and abilities. I agree that I will inform the massage therapist of any current or future health conditions so that they may adjust massage techniques accordingly.

I further understand and affirm that massage therapists are not equivalent to a medical doctor and cannot diagnose illness, disease or any other medical, physical, or emotional disorder, nor are they able or permitted to prescribe treatments for such disorders. I understand that I am responsible for consulting an appropriately licensed health practitioner for any ailments I have.

I understand that massage is a therapeutic health aide and is strictly NON-SEXUAL; sexual advances, remarks or similar inappropriate behavior will result in an immediate termination of the session and the full charge for my session will be assessed if applicable.

I affirm that I will inform my massage therapist of any pain or discomfort during the session so that they may adjust their technique accordingly.

SIGNED: _____ DATE: _____

BODY DIAGRAM

Please indicate areas of your body you would like focused on during your massage session by circling them on the diagram below.

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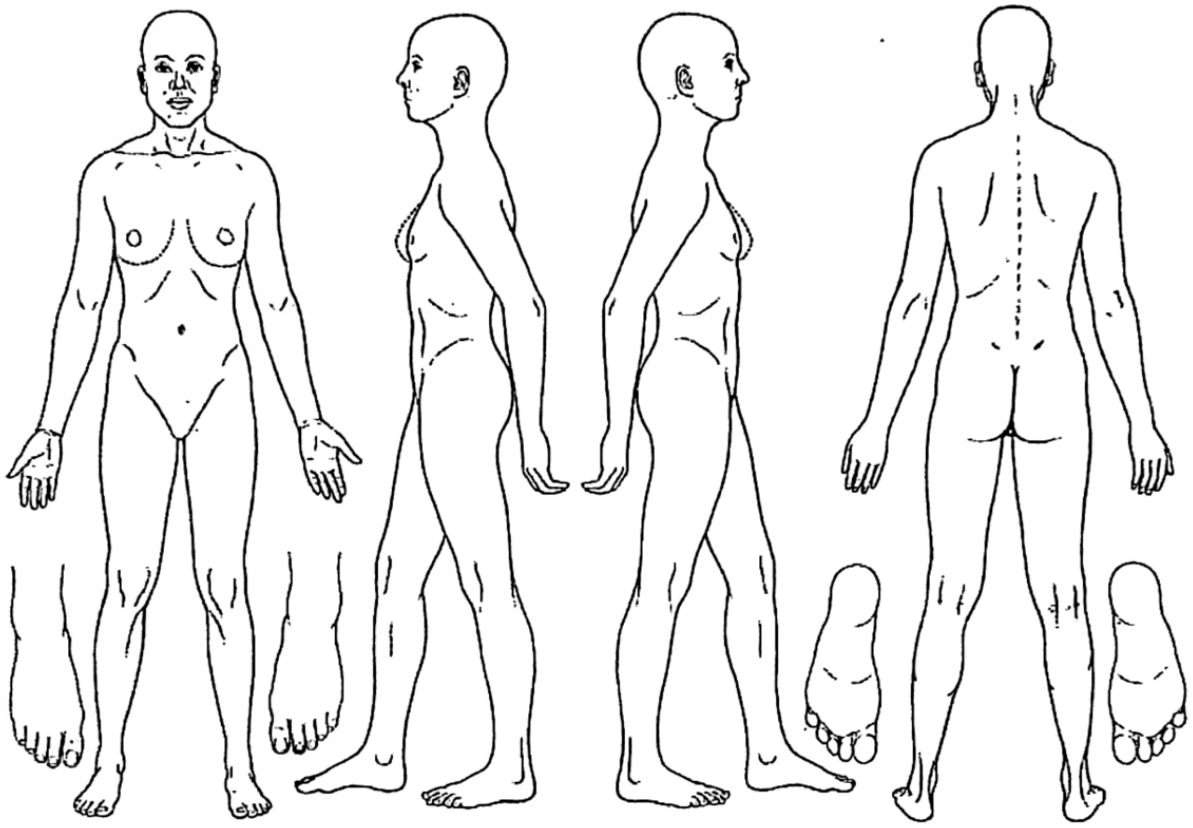

Use a pen or pencil to circle areas of focus. Bring this completed form to your appointment.