

ANGEL'S TOUCH SF — CLIENT INTAKE FORM

www.angelstouchsf.com | San Francisco, CA

CLIENT INFORMATION

Full Name: Melissa Zamora Date: Hahe 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: <input type="checkbox"/> BREATHING DIFFICULTY <input type="checkbox"/> EMPHYSEMA <input type="checkbox"/> ALLERGIES <input type="checkbox"/> SINUS PROBLEMS <input type="checkbox"/> ASTHMA	SKIN: <input type="checkbox"/> ALLERGIES <input type="checkbox"/> RASH <input type="checkbox"/> ATHLETES FOOT/FUNGAL INFECTION <input type="checkbox"/> BACTERIAL SKIN INFECTION <input type="checkbox"/> HERPES/COLD SORES <input type="checkbox"/> SCABIES/PARASITIC INFECTION
NERVOUS SYSTEM: <input type="checkbox"/> SHINGLES <input type="checkbox"/> NUMBNESS <input type="checkbox"/> TINGLING <input type="checkbox"/> PINCHED/IMPINGED NERVE <input type="checkbox"/> EPILEPSY	DIGESTIVE: <input type="checkbox"/> IRRITABLE BOWEL SYNDROME <input type="checkbox"/> ULCERS <input type="checkbox"/> OTHER: _____
REPRODUCTIVE: <input type="checkbox"/> PREGNANT: First, second, or third trimester? <input type="checkbox"/> OVARIAN/MENSTRUAL PROBLEMS <input type="checkbox"/> PROSTATE <input type="checkbox"/> OTHER: _____	OTHER: <input type="checkbox"/> CANCER/TUMORS <input type="checkbox"/> BLADDER/KIDNEY AILMENT <input type="checkbox"/> DIABETES <input type="checkbox"/> CHRONIC FATIGUE <input type="checkbox"/> CHRONIC PAIN
CHEMICAL: <input type="checkbox"/> MEDICAL/RECREATIONAL CANNABIS <input type="checkbox"/> ALCOHOL (if more than 1 drink per day) <input type="checkbox"/> TOBACCO <input type="checkbox"/> 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.

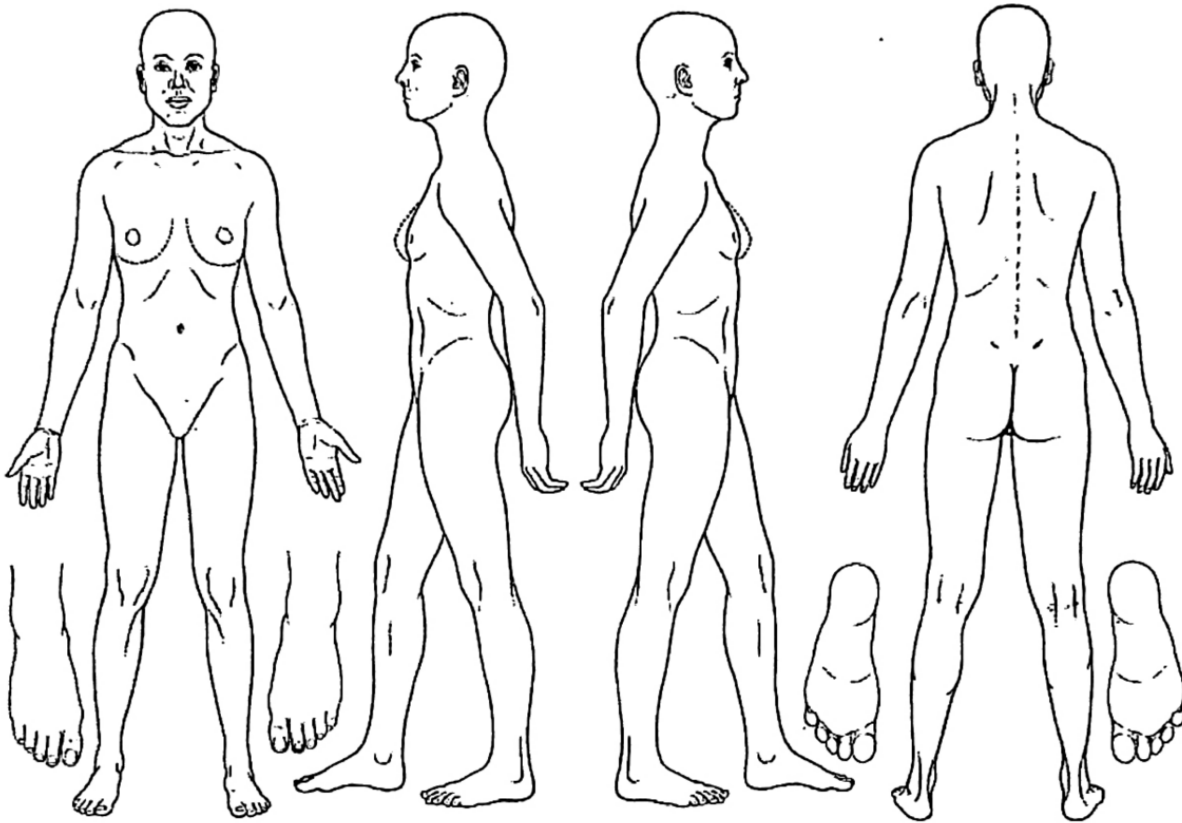
I affirm that I will inform my massage therapist of any pain or discomfort during the session so that they may adjust their technique accordingly.

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.

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



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