

**Angel Spa
Client Health History**

Name: _____ Today's date _____

Address _____

Email: _____ DOB _____

Occupation: _____ P _____

Who referred you, or how did you find out about our services? _____

What is the reason for your visit to our office _____

What results would you like to achieve with our work? _____

Have you seen a doctor or another health practitioner regarding this or similar conditions. ____ Yes ____ NO. If Yes

List their names and phone numbers. Do I have your permission to contact them?

When did you first notice the condition and what started it _____

What makes it worse ? Better? _____

Please indicate any of the following conditions that apply to you, Mark any current conditions with an "X" and past conditions with an "O"

- | | | |
|--|---|--|
| <input type="checkbox"/> Chronic pain, where
_____ | <input type="checkbox"/> Asthma | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Joint pain, where
_____ | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Muscle pain, where
_____ | <input type="checkbox"/> Frequent respiratory
illness | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Other Pain, Where
_____ | <input type="checkbox"/> Lung or respiratory
Condition | <input type="checkbox"/> Trouble
Concentration |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Cold hand/Feet | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Numbness, where
_____ | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Hearing Problem |
| <input type="checkbox"/> Broken bones, where
When _____ | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Sprain/Strains, Where
_____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Contacts |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Nervous System
Condition |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Bone disease | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Tumors/Cancer |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Shingles/herpes |
| | <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Pregnancies |
| | <input type="checkbox"/> Ulcers | <input type="checkbox"/> PMS |
| | <input type="checkbox"/> Digestive condition | <input type="checkbox"/> Hysterectomy |
| | <input type="checkbox"/> Bowel condition | <input type="checkbox"/> Menopause |
| | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Birth control |
| | | <input type="checkbox"/> Prostate |

Difficulty breathing

Panic attacks/anxiety

Reproductive
concerns

Sinus conditions

Hyperactivity

Explain any conditions noted above: _____

I have completed this information form to the best of my knowledge. I understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care when it is indicated. Information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion. Our time together is precious, and i agree to cancel 5 hours in advance.

Unless there is an emergency, if i miss an appointment, i agree to pay the full appointment fee.

Date: _____ Signature _____

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