Angel Spa

Client Health HIstory

Name: _____DToday 's date _____

Address_____

Eamil: _____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"

__Chronic pain, where _____

__Joint pain, where _____

__Muscle pain, where _____

---Other Pain, Where _____

__Headache

__Numbness, where _____

__Broken bones, where When_____

---Sprain/Strains, Where _____

---Arthritis

__Osteoporosis

---Bursitis

__Tendonitis

__Scoliosis

__Bone disease

__Dizziness

__Asthma

__Fatigue

__Frequent respiratory Illness

__Lung or respiratory Condition

__Cold hand/Feet

__Swollen ankles

__ Varicose Veins

__ High Blood Pressure

__Low Blood Pressure

__Lymphedema

__Heart condition

__Indigestion

__Loss of appetite

__Diarrhea

__Constipation

__Gas/Bloating

__Ulcers

__Digestive condition

__Bowel condition

__Eating disorders

__Learning difficulties

__Depression

__Trouble Sleeping

__Trouble Concentration

__Memory Loss

__Hearing Problem

__Vision Problems

__Contacts

__Paralysis

__Nervous System Condition

__Allergies

__Rashes

__Skin Conditions

__Tumors/Cancer

__Shingles/herpes

__Pregnancies

__PMS

__Hysterectomy

__Menopause

__Birth control

__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 _____

Angel Spa Address: 23420 Summerstown Place, Dulles, VA 20166 / P: 703-606-3806

Email: angelspanearyou@gmail.com : website: www.callangelteam.com