Angel Wellness

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? _____

Chronic pain? Where _____

_____

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 _____

Address: 23420 Summerstown Place, Dulles, VA 20166