AROMATOUCH TECHNIQUE CLIENT INTAKE FORM

Please take a moment to fill out the questionnaire below.

Name______________________________ Date of Birth_____________________________

Email_______________________________Telephone________________________________
Cell_________________________________FB/IG____________________________________

Address_____________________________City_________________Zip___________________

Are you currently/have you recently experienced any of the following?

Heart problems ______ High/low blood pressure ______ Over/Under active thyroid ______
Eczema ______ Skin Cancer ______ Cold sores______

Pregnant _______ Lactation________ Hormonal problems______

Allergies______ Diabetes______ Arthritis____________

Flu/Cold______ Tension or Pain_______ specific area ________________________________

Any other physical, mental or emotional concerns? ____

How much of the following do you drink daily? Water______ Coffee/Tea___________Alcohol_________

Are you currently taking any medication or supplements? Yes No If yes please specify:
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I have fully disclosed any physical concerns to the AROMATOUCH TECHNIQUE PROVIDER. I understand there may be some degree of discomfort after this procedure, such as, but not limited to, flu-like symptoms, headache, dizziness, and/or diarrhea. I have been informed to drink plenty of water after this procedure. I release the AROMATOUCH TECHNIQUE provider from any responsibility for symptoms related to the detoxification process incurred with this procedure.

Signature____Date__________________

Provider____

PARENTAL CONSENT REQUIRED

I____________________________ the parent/legal guardian of __________________, the underage recipient of the AROMATOUCH TECHNIQUE, give full permission to the provider to administer this procedure.

FOLLOW UP APPT IS STRONGLY SUGGESTED APPT DATE/TIME_______________________________