TouchChi Intake Form ***CONFIDENTIAL***

The following information is requested to better understand your desire for your session, and to tailor the experience to your individual needs.

Name: Telephone:

Address: City: State: Zip:

Email:

I heard about you from:

Do you have preferred days or times for scheduling with us? (e.g., Tues morning, Thu afternoon, Saturdays)

Are you currently taking any medications? If yes, please describe the medication and condition.

For the following, please note any conditions you currently have or have had in the past.

- Blood clot
- Hypertension/High-blood pressure
- Arthritis
- Back conditions
- Diabetes
- Skin Conditions
- Heart conditions
- Varicose Vein
- Broken/dislocated bones
- Bruise easily
- Fatigue
- Surgery
- Hemorrhaging
- Loss of muscle tissue
- Laminectomy of vertebrae
- Cancer/tumors
- Headaches
- Stroke
- Strains/sprains
- Whiplash
- Chronic pain
- Pregnancy

Details on above conditions, or other conditions not listed above:

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Do you have any of the following today? If yes, please provide more detail in the space provided.

Cold/flu/contagious ailment	Injuries/bruises	Open cuts
Severe pain	Skin rash	Swelling/inflammmation

Do you have allergies or reactions to the following? If yes, please provide more detail in the space provided.

Environmental allergens (e.g., fragrances, incense, dust, pollen)	Skin care products

Is there any other information we should know before proceeding with the massage?

What is your Intention for your session today?

As massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: Date: