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 _____ Eczema _____ Pregnant _____ Allergies_____ Flu/Cold_____ Cold sores_____

High/low blood pressure _____ Skin Cancer _____ Over/Under active thyroid _____ Diabetes_____

Hormonal problems_____ Arthritis _____ Lactation_____

Tension or Pain_____ Area of Body _____

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:

_____

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_____