



Ruthie's Angels

Ruthie's Angels Intake Form (please print)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: (____) _____ Secondary Phone: (____) _____

Email Address: _____

Date of Birth: _____ Sex (please check) Male Female

Occupation: _____

Physician

Primary Care Physician: _____

Symptoms/Treatment Information (mandatory)

Do you have any diagnosed medical conditions? No Yes, please explain: _____

Are you currently taking any medications? No Yes, please list: _____

Are you currently experiencing any physical pain or discomfort? No Yes, please explain: _____

Are you pregnant? No Yes; How many weeks? _____

Are there any health related conditions, concerns or questions that you wish to disclose or ask prior to your service? _____

Injury Specific Information (if applicable)

Are your injuries related to an accident? No Yes; Date of Accident: _____

Emergency Contact Information

Emergency Contact: _____

Contact Phone Number: _____ Relationship: _____

Contact Address: _____

Any other information, accommodations, or specific health related details

Release Authorization for Treatment

I authorize wellness and/or aesthetic treatment. I have answered the health related questions on this form honestly and completely. I understand that the providing company and/or therapist are not liable for any unforeseen medical issues that I may experience or complications that may arise that could be related to an undiagnosed, pre-existing medical condition prior to or after my treatment. I will disclose any concerns; health related or otherwise as well as discuss any pre-existing conditions to my therapist prior to receiving a treatment.

Patient Signature: _____ Date: _____
(Parent/Guardian if patient is a minor)

Cancellation Policy

If you need to cancel or reschedule an appointment, please give us at least 12 hours notice prior to your service. This is a courtesy to our therapist and will enable us to accommodate other clients. Identified Ruthie's Angels clients may be at risk of losing their eligibility to receive discounted/complimentary services if the cancellation policy is not abided by. _____ (Client Initial)

***Please fill this intake form out and return to Ruthie's Angels at: P.O. Box 657, Maumee, Ohio 43537
Attention: Ruthie's Angels Recipient**