



Client Update

Please complete all questions to the best of your ability.

Name: _____ DOB: _____

Please answer the following with "YES" or "NO".
Explain if necessary

Skin Problems _____	Arthritis _____	High/Low Blood Pressure _____
Blood Clots _____	Diabetes _____	Varicose Veins _____
Seizures _____	Pregnant _____	Circulatory Disorders _____
Contact Lens _____	Cancer _____	Contagious Diseases _____

Explain any "YES" answers

Current Medications: _____

Allergies: _____

Please list any other medical conditions, major illnesses, broken bones, surgeries, or accidents in the past year: _____

To the best of my knowledge, the information I have provided is accurate and true. I understand that if at any time I am uncomfortable with the massage or any techniques being used I can ask the therapist to stop, change techniques, or end the session. I also agree to notify the therapist of ANY changes to my medical status, medical procedures, and/or medications.

Client Signature: _____ Date: _____