Returning Client Intake Form

Name _____ Date _____

Based on the information provided in your initial consultation form, have any of these conditions changed since your last massage:

Areas of swelling	Decreased sensation	Neuropathy Osteoarthritis
Autoimmune disorder	Diabetes	Osteoporosis Phlebitis
Back / neck problems	Fibromyalgia	Sciatica
Bleeding disorders	Headaches	Seizures
Blood clots	Heart condition	Stroke
Bruise easily	Hypertension	Tendinitis
Bursitis	Kidney disease	TMJ disorder
Cancer	Multiple sclerosis	Varicose veins
Contagious condition	Neurological condition	Vertigo / dizziness

If you circled any of the above conditions or if you have any new conditions not listed above, please explain in detail below:

_____

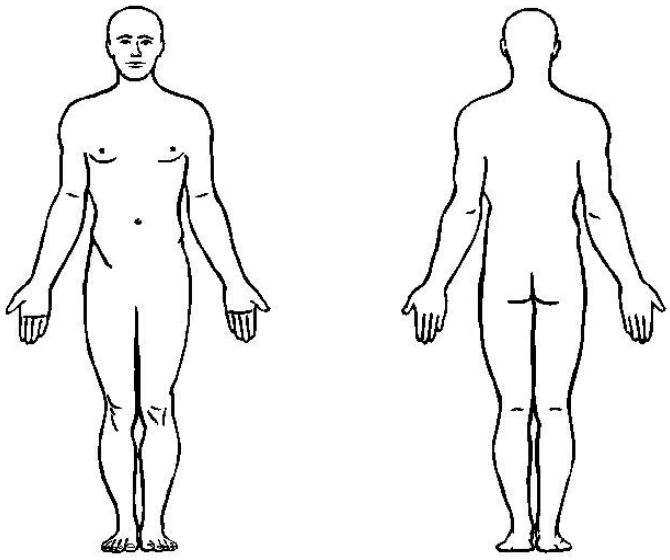
_____

_____

In the past 14 days have you been in contact with anyone who has been diagnosed with COVID-19 or is experiencing covid/flu-type symptoms? YES _____ NO _____

Are you currently experiencing any respiratory, flu-type symptoms? YES _____ NO _____

Please indicate areas of discomfort below:



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

_____ _____

CLIENT SIGNATURE DATE