RENOVO
Integrative Massage & Renewal

CLIENT INTAKE FORM

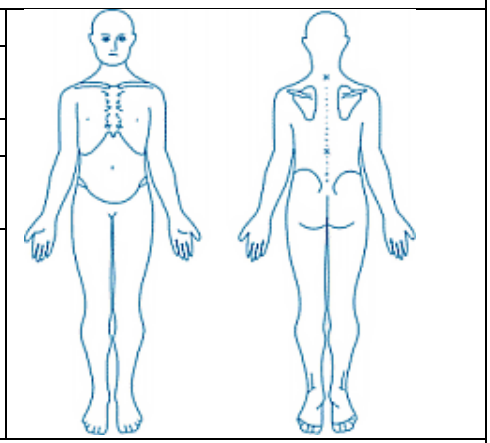
Name (please print) Last Name First Name

1. **ARE YOU EXPERIENCING ANY OF THE FOLLOWING?** Check all that apply. Date:

	Pregnancy		Bleeding		Skin Problems		Cancer
	Varicose Veins		Fever		Nausea/Vomiting		Arthritis
	Heart Problems		Gout		Bursitis		Diabetes
	Other:						

2. **TENSION AND DISCOMFORT DIAGRAM:**

On the diagram to the right ( ), shade in the area(s) where you are experiencing muscle tension or bodily discomfort



3. **MEDICAL HISTORY UPDATE:**

Since your last appointment, have there been any changes to your medical history?	NO	YES

If YES, please explain:

Additional information for your therapist:

Allergies to any lotions/oils? **Y** / N (If yes, please specify _____

Wear contact lenses? **Y** / N

Other information

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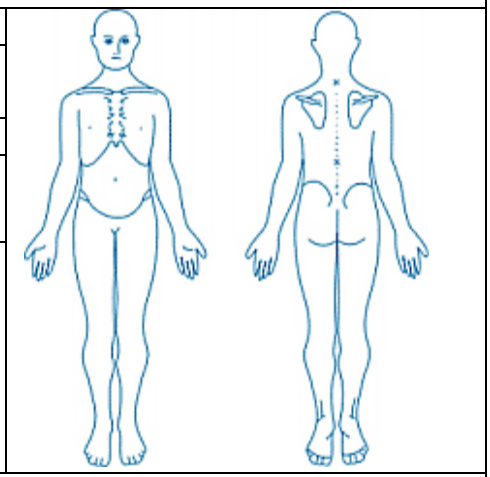

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