Client Update

Client Name ____ Date ____/____/_______

I understand that certain treatments may be contraindicated if I have a specific medical condition or specific symptom.

☐ There have been no changes to my health since my initial interview on ____/____/_______

☐ There have been changes to my health since my initial interview on ____/____/_______ as follows:
____

Please take a moment to carefully read the information that you have provided and sign where indicated. If you have a specific medical condition or medication, certain treatments may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Client Signature ____

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