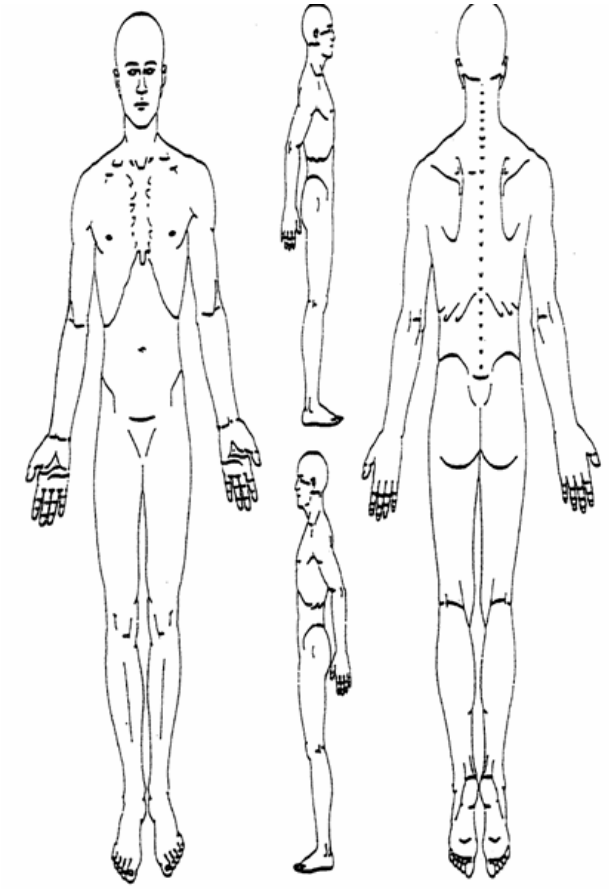
Returning Client Form

Client's Name: _____

Type of Service: _____

Please circle and mark any specific areas you would like me to concentrate on or relieve during the session.
Mark Areas with following: P (Pain) T (Tight) S (Stiffness) F (Focus) X (Tingling/Numbness)



Therapist use only

SOAP NOTES _____
_____
_____
_____
_____
_____
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_____
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_____

What is your goal for today's session? _____
_____

What kind of pressure do you prefer today? _light _firm _medium _deep

Rate your level of pain if you have any today: 1 2 3 4 5 6 7 8 9 10

Have you been sick within 24 hours of this appointment date? _ yes _ no If yes Explain _____
_____

Has any of your personal information changed since your last visit? _ yes _ no If yes explain _____
_____

Client name Print: _____
Client Signature: _____ Date: _____
Therapist Signature: _____ Date**:** _____