p. 708.354.9599
f. 708.354.9799

442 Sherwood Road
LaGrange Park, IL 60526

www.CompleteRehabilitation.net

MASSAGE THERAPY

First Name: ________________________ Middle Initial: _________ Last Name: ___________________________

Address: ____

City: ____ State: ________ Zip Code: ___________________________

Home Phone: _________________ Cell Phone: _________________ Work Phone: _________________________

Date of Birth: ________________________ Occupation: ____

Emergency Contact Name: ____ Phone: ___________________________

How did you hear about us? ____ Email: ____________________________

Please read the following information carefully. If you have any health conditions or specific symptoms, massage/ bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being rendered. Please check all that apply below and your Massage Therapist will discuss them with you before the session begins.

1. ▪Yes ▪No Have you ever experienced a professional massage or bodywork session?
   If yes, how recently? ____
2. ▪Yes ▪No Do you have tension or soreness in a specific area?
   Please specify. ____
3. ▪Yes ▪No Frequently suffer from stress
4. ▪Yes ▪No Experience frequent headaches
5. ▪Yes ▪No High or low blood pressure
6. ▪Yes ▪No Cardiac or circulatory problems
7. ▪Yes ▪No Respiratory problems
8. ▪Yes ▪No Stomach/Intestinal problems
9. ▪Yes ▪No Kidney problems
10. ▪Yes ▪No Back pain
11. ▪Yes ▪No Tingling, numbness or stabbing pains anywhere
12. ▪Yes ▪No Diabetes
13. ▪Yes ▪No Epilepsy or seizures
14. ▪Yes ▪No
15. ▪Yes ▪No Experience joint swelling
16. ▪Yes ▪No Arthritis
17. ▪Yes ▪No Osteoporosis
18. ▪Yes ▪No Have had joint dislocations
19. ▪Yes ▪No Any broken bones in the past 2 years (if yes, please list below)
20. ▪Yes ▪No Sensitive to touch/pressure in any area (if yes, please list below)
21. ▪Yes ▪No Bruise easily
22. ▪Yes ▪No Varicose Veins
23. ▪Yes ▪No Lymphedema
24. ▪Yes ▪No Skin rashes, open wounds, or fungus
25. ▪Yes ▪No Any communicable infections or contagious diseases (if yes, please list below)
26. ▪Yes ▪No Allergies
27. ▪Yes ▪No Pregnant
28. ▪Yes ▪No Wear contact lenses
29. ▪Yes ▪No Have dentures
30. ▪Yes ▪No Diagnosed with cancer
31. ▪Yes ▪No Accidents or injuries in the past 2 years (if yes, please list below)
32. ▪Yes ▪No Are you taking medications (if yes, please list below)
33. ▪Yes ▪No Have you ever had surgery
34. ▪Yes ▪No Do you have any other medical conditions? Explain below.

Comments: ____
____
____
____

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CLIENT / THERAPIST RELEASE AND AGREEMENT

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress relief, or pain control. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness or disease, and that nothing said in the course of the session should be construed as such. I further understand that the massage or bodywork should not be a substitute for medical examination, diagnosis or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure/ stokes may be adjusted to my level of comfort. I understand that massage/bodywork sessions are performed in a professional manner and that any illicit or sexually aggressive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the schedule appointment. Draping will be used at all times during the therapy session and if I feel uncomfortable I will immediately tell the practitioner so that it may be adjusted.

I affirm that I have stated all my known medical conditions clearly and honestly and am aware that massage/bodywork should not be performed under certain medical conditions. My practitioner has the right to refuse service based on my health questionnaire. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that I am financially responsible for the service that I receive at Complete Rehabilitation. I also understand that should any unpaid balance due that I owe be placed with a third party collection agency or attorney, an additional 40% of the unpaid balance along with attorneys fees will be added to reimburse Complete Rehabilitation for the costs of collections.

______________________________	______________________________	________________
Name (please print)	Signature	Date

Minor Guardian Permission

If you are under the age of 18, please have your parent or guardian sign the following prior to your massage session.

As the parent or guardian of ____, age _______, I give my permission for him/her to receive massage therapy services at Complete Rehabilitation. This permission will remain in effect until revoked by the undersigned in writing. I have read and understand the client/therapist release and agreement and acknowledge that all standard terms, conditions and agreements of Complete Rehabilitation will apply to my child.

Special Request: ____

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______________________________	______________________________	________________
Parent Name (please print)	Signature	Date