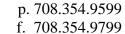


442 Sherwood Road LaGrange Park, IL 60526

www. Complete Rehabilitation. net

MASSAGE THERAPY

]	First Name:			Middle Initial:			Last Name:			
	Address	s:								
(City:				State:		Zip C	Code:		
								Phone:		
				•						
	Emerge	ncy Co	ntact Name:				Pł	none:		
]	How di	d you h	ear about us?				Er	nail:		
boo	dywork	may be	e contraindicated. A referra	ıl from your	r primary ca	are pro	vider m	s or specific symptoms, massage/ ay be required prior to service being cuss them with you before the session		
1.	•Yes	•No	Have you ever experienced a pr If yes, how recently?							
2.	•Yes	·No	Do you have tension or sorenes Please specify							
3.	•Yes	•No	Frequently suffer from stress		21.	•Yes	•No	Bruise easily		
4.	•Yes	•No	Experience frequent headaches		22.	•Yes	•No	Varicose Veins		
5.	•Yes	•No	High or low blood pressure		23.	·Yes	•No	Lymphedema		
6.	•Yes	•No	Cardiac or circulatory problems		24.	·Yes	•No	Skin rashes, open wounds, or fungus		
7.	•Yes	•No	Respiratory problems		25.	•Yes	•No	Any communicable infections or contagious diseases (if yes, please list below)		
8.	•Yes	•No	Stomach/Intestinal problems		26.	·Yes	•No	Allergies		
9.	•Yes	•No	Kidney problems		27.	•Yes	•No	Pregnant		
10.	•Yes	•No	Back pain		28.	·Yes	•No	Wear contact lenses		
11.	•Yes	•No	Tingling, numbness or stabbing		29.	•Yes	•No	Have dentures		
			pains anywhere		30.	•Yes	•No	Diagnosed with cancer		
12.	•Yes	·No	Diabetes		31.	•Yes	•No	Accidents or injuries in the past 2 years (if yes, please list below)		
13. 14.	·Yes ·Yes	·No ·No	Epilepsy or seizures		32.	•Yes	•No	Are you taking medications (if yes, please list below)		
15.	•Yes	•No	Experience joint swelling		33.	·Yes	•No	Have you ever had surgery		
16.	·Yes	•No	Arthritis		34.	•Yes	•No	Do you have any other medical conditions?		
17.	•Yes	•No	Osteoporosis					Explain below.		
18.	•Yes	•No	Have had joint dislocations		Comr	ments: _				
19.	•Yes	•No	Any broken bones in the past 2 years (if yes, please list below)							
20.	•Yes	•No	Sensitive to touch/pressure in a area (if yes, please list below)	nny						





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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 p	parent or guardian sign the following pr	ior to your massage session.
As the parent or guardian of		, age, I give my
As the parent or guardian ofpermission for him/her to receive massage therap		
effect until revoked by the undersigned in writing		
and acknowledge that all standard terms, condition	ons and agreements of Complete Rehabil	itation will apply to my child.
Special Request:		