re:fit
910 Waukegan Road
Glenview, IL 60025

(p) 847.657.0881
(f) 847.657.0882

Massage Client Information:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (PLEASE CHECK THE PREFERRED NUMBER FOR MESSAGES)

❍ HOME _____

❍ WORK _____

❍ CELL _____

What's the earliest/latest we can phone your home _____

Email: _____

Occupation: _____

Date of Birth: _____ **Gender Identity:** _____

Physician: _____ **Referred by:** _____

Emergency Contact: _____

Relation: _____

Phone Number: _____

Client Medical History:

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ❍ YES ❍ NO

If yes, how recently? _____

What are your massage or bodywork goals?

_____

What kind of pressure do you prefer? Light Medium Firm

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If you answer "yes" to any of the following questions, please explain as clearly as possible in the space below.

Do you frequently suffer from stress?	❍ YES	❍ NO
Do you have diabetes?	❍ YES	❍ NO
Do you experience frequent headaches?	❍ YES	❍ NO
Are you pregnant?	❍ YES	❍ NO
Do you suffer from arthritis?	❍ YES	❍ NO
Are you wearing contact lenses?	❍ YES	❍ NO
Are you wearing dentures?	❍ YES	❍ NO
Do you have high blood pressure?	❍ YES	❍ NO
Are you taking high blood pressure medication?	❍ YES	❍ NO
Do you suffer from epilepsy or seizures?	❍ YES	❍ NO
Do you suffer from joint swelling?	❍ YES	❍ NO
Do you have varicose veins?	❍ YES	❍ NO
Do you have any contagious diseases?	❍ YES	❍ NO
Do you have osteoporosis?	❍ YES	❍ NO
Do you have any allergies?	❍ YES	❍ NO
Do you bruise easily?	❍ YES	❍ NO
Any broken bones in the past two years?	❍ YES	❍ NO
Any injuries in the past two years?	❍ YES	❍ NO
Do you have tension or soreness in a specific area?	❍ YES	❍ NO
Do you have cardiac or circulatory problems?	❍ YES	❍ NO
Do you suffer from back pain?	❍ YES	❍ NO
Do you have numbness or stabbing pains?	❍ YES	❍ NO
Are you sensitive to touch or pressure in any area?	❍ YES	❍ NO
Have you ever had surgery? Explain below.	❍ YES	❍ NO
Other medical conditions not previously mentioned?	❍ YES	❍ NO

Please explain:

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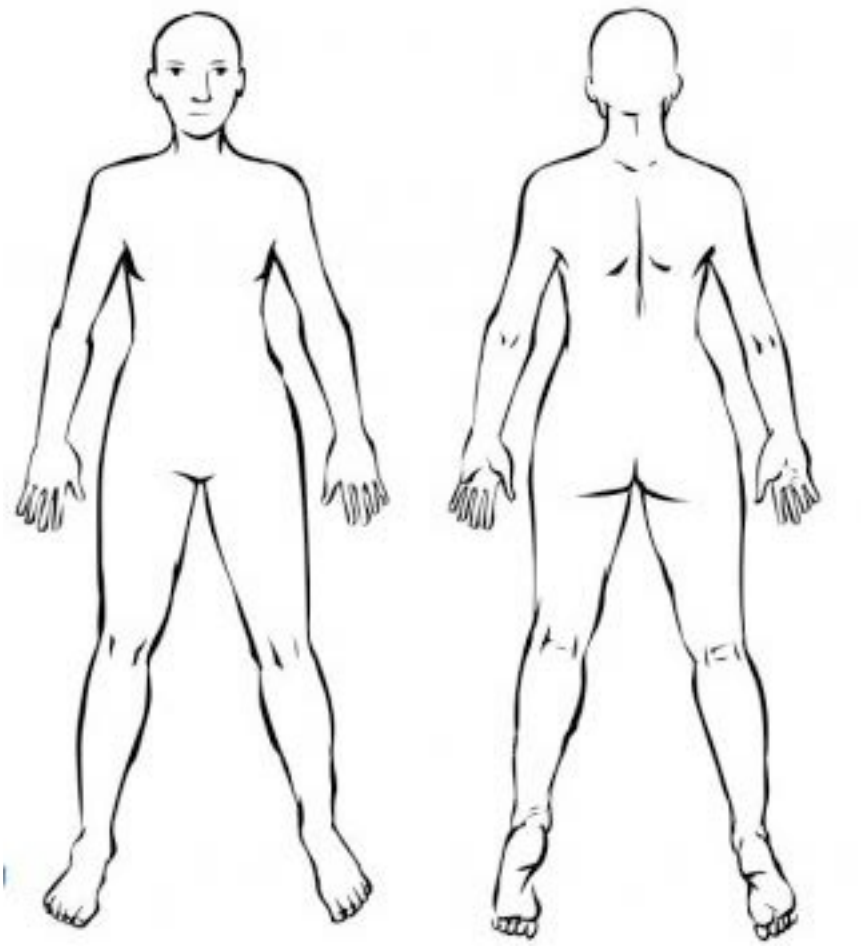
Body Map



Client: _____ **Date:** _____

Observations/Recommendations:

_____

_____

Range of Motion:_____% **Pain Threshold:** High Low

Client Preferences:

_____

Please mark areas of pain or limitations.

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Acknowledgement and Consent to receive services:

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. 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 also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Signature: _____ Date: _____

Practitioner's Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

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Client Cancellation and Payment Policy

Re:fit patients are seen by appointment only. Scheduling is based on a first come-first served basis. To receive the full benefit of your session, please arrive on time. If you have a standing appointment and are going to be out of town, please let us know as soon as possible.

Cancellation Policy

Cancelling An Appointment With No Charge: To cancel an appointment with no charge we require a twenty-four (24) hour notice. This notice must be given directly to re:fit by calling 847-657-0881. Notice provided to a therapist is not sufficient.

Cancellation Fee: A cancellation fee of 50% of the fee of service applies if you cancel your appointment less than 24 hours of the scheduled appointment time.

Full Price Required: If you do not call to cancel an appointment, you will be charged the full price of the session.

Payment Policy: Payment is due at time of service.

Collection Action:

I, the undersigned, understand and agree that if collection action should become necessary for recovery of any monies due under services rendered or products purchased, I am responsible for any and all collection costs, court costs, and attorney fees. I also understand and agree that accounts with balances outstanding more than thirty days from the date of service or purchase will be charged a service fee of 5% per month of the outstanding balance, until the balance is paid in full.

By signing below, I agree to abide by the Cancellation and Payment Policies of re:fit, inc.

CLIENT'S SIGNATURE DATE