

**Name of Client:**

## Massage Client Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred phone #     Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

What's the earliest/latest we can phone your home? \_\_\_\_\_

Email \_\_\_\_\_ Gender identity \_\_\_\_\_ Pronoun pref \_\_\_\_\_

Physician \_\_\_\_\_ Referred by \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone Number \_\_\_\_\_

## Client Medical History

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

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

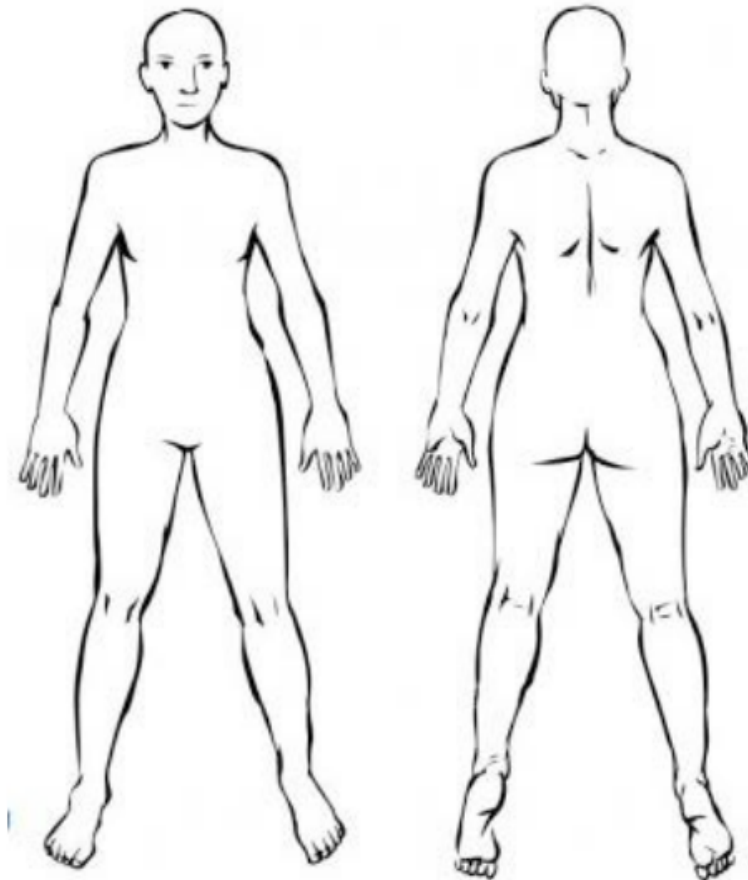
Please explain if you answered "Yes" to any of the questions above



**Name of Client:**

## Body Map

Please mark areas of pain or limitations.



Client

Date

Observations/Recommendations:

Range of Motion:

%

Pain Threshold:

High

Low

Client Preferences:



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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 inappropriate 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.

CLIENT SIGNATURE

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE

PRACTITIONER SIGNATURE

DATE

## Client Cancellation and Payment Policy - Massage

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 are going out of town or need to miss an appointment, please cancel any "standing appointments" as soon as possible.

**Cancelling An Appointment With No Charge/ 24 Hours:** To cancel an appointment with no charge we require **at least** 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.*

**75% Cancellation Fee/ 6-24 Hours:** If you call re:fit directly and cancel your appointment between 6-24 hours of the scheduled time, there will be a 75% fee of the visit's charge.

**Full Price Cancellation Fee/ 0-6 Hours or No Show:** If you cancel less than 6 hours before your scheduled visit, or 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, p.c.

CLIENT SIGNATURE

DATE