



3450 Montgomery Rd Suite 21 Aurora, IL 60504 Ph # (630) 236-8600 Fax # (630) 236-8612

### Personal Information

First Name: _____	Last Name: _____	M / F _____
Address: _____	City: _____	State: _____
Zip Code: _____	E-mail Address: _____	
Date of Birth: ___/___/___	Occupation: _____	
Home Phone: (____) _____ - _____	Work Phone: (____) _____ - _____	
Referred By: _____	Emergency Contact: _____	
Relationship: _____	Phone Number: (____) _____ - _____	

### History

Please describe the area of complaint: _____
Is your complaint due to: Accident / Injury at work / Injury at home / Lifting / Falling / Stress / Auto Accident / Sports / Other _____
How long has this condition lasted? _____
Date complaint began: ___/___/___ Have you had this before? _____

### Medical Information

Are you currently taking any medication? Y / N Which one(s)? _____
Do you have any allergies? Y / N please list: _____
Are you currently under the care of a physician or psychologist? Y / N
Please Indicate: _____
Have you ever had surgery: Y / N When/Where? _____
Name of Physician: _____ Phone Number: (____) _____ - _____

**Please Check All That Apply In Past Medical History**

- Allergies
- Broken Bones
- Diarrhea
- High Cholesterol
- Paralyzes
- AIDS/HIV
- Burns
- Dizziness
- Insomnia
- Prosthetics
- Anemia
- Cancer/Tumors
- Epilepsy
- IUD
- Pregnant
- Arteriosclerosis
- Chronic Bronchitis
- Fatigue
- Joint Pain
- Rash
- Arthritis
- Circulatory Problems
- Fractures
- Kidney Disease
- Sinusitis
- Asthma
- Constipation
- Headaches
- Liver Disorders
- Skin Problem
- Athlete's Foot
- Contact Lenses
- Hernia
- Lung Disease
- Back Pain
- Bruise Easily
- Cuts or Sores
- Herpes
- Nervousness
- Stroke
- Blood Clots
- Diabetes
- High Blood Pressure
- Ulcers
- Varicose Veins
- Other \_\_\_\_\_

I understand the therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session(s), 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 soft tissue work should not be construed as a substitute for medical examination, diagnosis, or treatment. Because soft tissue work 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 massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist fault should I forget to do so. It is also understood that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the session.

**Signature:** \_\_\_\_\_  
(Parent/Guardian Signature required if under the age of 18)

**Date:** \_\_\_\_\_