# MASSAGE THERAPY RELEASE FORM

Name:_____
Address:_____ Zip code:_____
Phone Number:_____ (Cell/Home)
Email:_____
How would you like your appointments confirmed?
Phone/Email/Text Message

PLEASE REVIEW THIS LIST AND CIRCLE ANY ILLNESS AND/OR MEDICAL CONDITIONS WHICH

APPLY **CURRENTLY OR IN THE LAST FIVE YEARS.**

**Heart Condition**
**Ruptured or bulging disc**
**Infectious conditions**
**Diabetes**
**Pins/Needles**
**Pregnancy Trimester_____**
**High Blood Pressure**
**Varicose veins or blood clots**
**Fibromyalgia**
**Digestive problems**
**Mental illness**
**Cancer_____**
**Constipation**
**Edema**
**Insomnia**
**TMJ disorder**
**Multiple Sclerosis**
**Numbness or stabbing pains**
**Frequent headaches**
**Low blood pressure**
**Allergies**
**Osteoporosis**
**Easy Bruising**
**Circulatory problems**
**Back Pain**
**Chronic fatigue**
**Dizziness/fainting**
**Kidney disorders**
**Seizures**
**Arthritis (Where_____)**
**Phlebitis**
**Loss of balance**
**Skin rashes**
**Anxiety Disorder**
**Other (Parkinson's, Bursitis, plantar Fascinates etc)** _____

Do you wear any of the following? HEARING AID? _____ CONTACTS?_____
DENTURES?_____ PACEMAKER?_____

**Did you come in today for a Relaxation massage_____ or**
**An area that you would specifically liked worked on** _____

**In which part of your body do you experience stress?**
_____

**How much pressure do you prefer? Light_____ Moderate_____ Heavy_____**

**Is your stress level? Light_____ Moderate_____ Heavy _____**

List injuries **NOT REQUIRING SURGERY** that occurred within the past 2 years. (I.E. broken bones, Torn ligaments, auto accident)

_____

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE (include over the counter medications as well as vitamins/herbs)

_____

Are you sensitive to touch in any area?

_____

Please circle your level of exercise (several times per day, Per Week, or rarely)

Please describe your type of exercise

_____

## Please take a moment and carefully read the following information and sign where indicated.

I understand that this information will be treated confidentially. In order to maximize the effectiveness and safety of massage sessions, I agree to give feedback during and at the end of my sessions. I understand that I will need to update my therapist on my health and well-being prior to each session. I understand that the massage/bodywork I receive is provided for the relief of muscular tension and soreness. If I experience any pain or discomfort during this session, I will immediately inform the therapist. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any physical or mental ailment of which I am aware. I understand that massage therapists/bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or emotional conditions and that nothing said during the course of treatment should be construed as such.
I affirm that I have stated all my known medical conditions and have answered all questions honestly. I understand that there shall be no liability on the practitioner's part should I forget to do so.

**Print Name _____ Date _____**

**Sign Name _____ Date _____**