



Massage Release Form

Name: _____ Today's Date: _____
 Address: _____ City: _____ State: _____ Zip _____
 Occupation: _____ Home #: _____ Cell #: _____ Wk#: _____
 E-Mail: _____ Date of Birth: _____

Whom may I thank for your referral? _____

Emergency Contact Name and Phone#: _____

Have you had massage before? _____ If yes, what kind of massage? _____

Are you basically in good health? _____ Any injuries in the past 72 hours? _____ Explain _____

Has there been any change to your health in the past year? _____

If yes, explain: _____

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 care provider may be required prior to service being provided.

Please initial by the appropriate box. Check if you have now or have ever had the following:

- | | | |
|--------------------------------------|---------------------------------------|-----------------------------------|
| Arthritis _____ | Autoimmune Disease _____ | Bruise easily _____ |
| Cancer _____ | Currently Pregnant _____ | Dentures _____ |
| Allergies _____ | Diabetes _____ | Epilepsy _____ |
| Carpal Tunnel _____ | High Blood Pressure _____ | TMJ _____ |
| Sciatica _____ | Migraines _____ | Psychotherapy _____ |
| Cardiac Problems/Pacemaker _____ | Foot Problems _____ | Rotator Cuff injury _____ |
| Scoliosis _____ | Temperature sensitivity _____ | Varicose Veins _____ |
| Vertebral disc problems _____ | Skin problems _____ | Blood Disorders _____ |
| Motor vehicle accident/ trauma _____ | Hearing problems _____ | Transdermal Patch _____ |
| Osteoporosis _____ | Do you regularly feel stressed? _____ | Have you had any surgeries? _____ |

Please let us know about any other medical condition or anything else you think is important for your therapist to know

Please explain any "Yes" answers

Please list all medications you are currently taking or using (prescription and non-prescription):

Informed Consent: The above information is accurate and complete. To the best of my knowledge, my health is appropriate for massage therapy or bodywork. I agree to inform the therapist of any pain experienced during the massage session. I understand that since massage is contraindicated in some medical conditions, that it may be necessary to obtain a doctor's release prior to beginning therapy. I understand that massage therapy should not be considered a substitute for medical examination, diagnosis or treatment, and that I should see a medical or chiropractic physician or other healthcare specialist. The massage therapist is not a doctor and cannot provide medical treatment, nothing said in the course of the session should be construed as such. I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so. I agree to hold harmless Serendipity Wellness Studio, Jennifer Ferdinand and any employees or independent contractors from and against any and all claims.

Client Signature: _____ Date: _____