MASSAGE RELEASE FORM

ABOUT YOU

NAME:		NICKNAME: OR PREFERRED NAME	
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:	EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:	MARITAL STATUS:	GENDER:
HOW DID YOU HEAR ABOUT OUR OFFICE:		APPROXIMATE DATE OF LAST PROFESSIONAL MASSAGE:	

HEALTH CONDITIONS

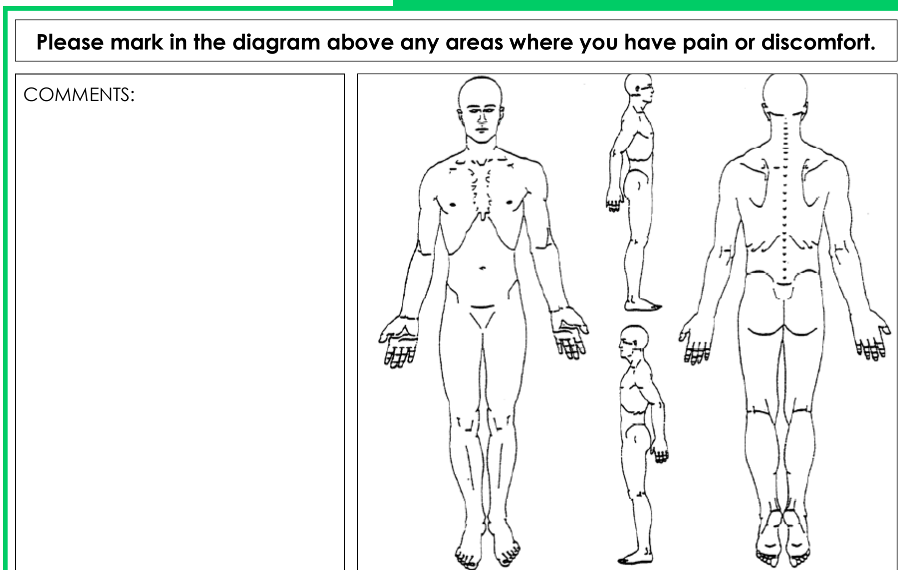
INSTRUCTIONS: ***Please check any of the following conditions or symptoms that you currently have or have had in the past.***

❑ SEVERE OR FREQUENT HEADACHES/MIGRAINES	❑ THYROID PROBLEMS	❑ PAIN IN ARMS/ LEGS/HANDS	❑ DIABETES	HAVE YOU BROKEN ANY BONES IN THE PAST 2 YRS? ❑ YES ❑ NO
❑ HEART SURGERY/ PACEMAKER	❑ SINUS PROBLEMS	❑ OSTEOPOROSIS	❑ ARTHRITIS	ARE YOU PREGNANT? ❑ YES ❑ NO
❑ LOWER BACK PROBLEMS	❑ EPILEPSY OR SEIZURES	❑ RHEUMATIC FEVER	❑ NUMBNESS	ARE YOU NURSING? ❑ YES ❑ NO
❑ FREQUENT NECK PAIN	❑ DIFFICULTY BREATHING	❑ ULCERS/COLITIS	❑ ALLERGIES	DO YOU WEAR CONTACT LENSES? ❑ YES ❑ NO
❑ PAIN BETWEEN SHOULDERS	❑ KIDNEY PROBLEMS	❑ LIVER CONDITION	❑ ASTHMA	DO YOU WEAR DENTURES? ❑ YES ❑ NO
❑ CARDIAC OR CIRCULATORY PROBLEMS	❑ HIGH BLOOD PRESSURE	❑ ARTHRITIS	❑ LOSS OF SLEEP	**PLEASE LIST ANY MEDICATIONS CURRENTLY TAKING:**
❑ DIGESTIVE PROBLEMS	❑ CANCER	❑ BRUISE EASILY	❑ DIZZINESS	
❑ OTHER:				

DURING THE MASSAGE

Please mark in the diagram above any areas where you have pain or discomfort.

COMMENTS:



DURING THE MASSAGE

PLEASE LIST ANY AREAS YOU ARE SENSITIVE TO TOUCH OR PRESSURE?

PLEASE LIST ANY OILS, LOTIONS, OR SCENTS YOU ARE ALLERGIC OR SENSITIVE TO?

DO YOU PREFER LIGHT, MODERATE, OR FIRM PRESSURE?

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MAY ASSIST THE THERAPIST IN PROVIDING A BENEFICIAL & THERAPEUTIC MASSAGE (GOALS, INJURIES, SPECIAL INSTRUCTIONS, ETC):

YOUR INTERESTS...

INSTRUCTIONS: *Please check all items that you may be interested in.*				
❑ WELLNESS TESTING	❑ WELLNESS PROGRAM	❑ WEIGHT LOSS	❑ HORMONE TESTING	❑ NEUROTRANSMITTER TESTING
❑ FOOD SENSITIVITIES	❑ HEAVY METAL TESTING	❑ CLEANSING | DETOX	❑ VITAMINS | SUPPLEMENTS	❑ NUTRITIONAL COUNSELING
❑ CHIROPRACTIC	❑ MEDITATION	❑ MASSAGE THERAPY	❑ REIKI	❑ HEALTHY COOKING CLASSES
❑ YOGA	❑ COLD LASER THERAPY	❑ KINESIOTAPING	❑ DECOMPRESSION	❑ HEALTHY LIVING WORKSHOPS

AUTHORIZATION FOR CARE

Please initial on each line confirming that you have read and understand the following:

_______ 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 the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

_______ I understand that massage/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 practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or 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 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 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.

_______ I understand that cancellations or changes to an appointment must be made 24 hours in advance. I hereby authorize Optimal Wellness Center of Indiana, LLC to charge a $50 service fee for all no show appointments and cancellations made outside the normal policy.

By signing this release, I hereby waive and release my therapist and Optimal Wellness Center of Indiana, LLC from any and all liability, past, present, and future relating to massage therapy and bodywork.

SIGNATURE:	DATE:

CONSENT TO TREATMENT OF MINOR: By my signature below, I hereby authorize a State Certified Massage Therapist at Optimal Wellness Center of Indiana, LLC to administer massage to my child or dependent, as they deem necessary.

GUARDIAN AUTHORIZING CARE SIGNATURE:	GUARDIAN'S NAME (PLEASE PRINT):	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT? ❑ PATIENT ❑ SPOUSE ❑ PARENT

FOR OFFICE USE ONLY: