Massage Release Form

Date _____/_____/_____

-Mandatory by Oklahoma State Law-

Name:_____ Occupation:_____

Age:_____ Male___ Female___ Physician _____

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 may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? How recently? _____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

YES NO

____ ____ Do you frequently suffer from stress?
____ ____ Do you have diabetes?
____ ____ Do you experience frequent headaches?
____ ____ Are you pregnant?
____ ____ If so, are you past your 1st trimester?
____ ____ Do you suffer from arthritis?
____ ____ Are you wearing contact lenses?
____ ____ Are you wearing dentures?
____ ____ Do you have high blood pressure?
____ ____ If "yes" to previous questions, are you taking medication for this?
____ ____ Do you suffer from epilepsy or seizures?
____ ____ Do you suffer from joint swelling?
____ ____ Do you have varicose veins?
____ ____ Do you have any contagious disease?
____ ____ Do you have osteoporosis?
____ ____ Do you have allergies?

YES NO

____ ____ Have you had any broken bones in the past two years?
____ ____ Have you been in an accident in the past two years?
____ ____ Do you have cardiac or circulatory problems?
____ ____ Do you suffer from back pain?
____ ____ Do you have numbness or stabbing pains?
____ ____ Are you sensitive to pressure anywhere?
____ ____ Have you had surgery?
____ ____ Do you have tension or soreness in a specific area?

_____
_____

____ ____ Do you have any other medical condition or taking medicine that I should know about?

_____
_____
_____
_____
_____
_____

I understand that the message/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience 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 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 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.

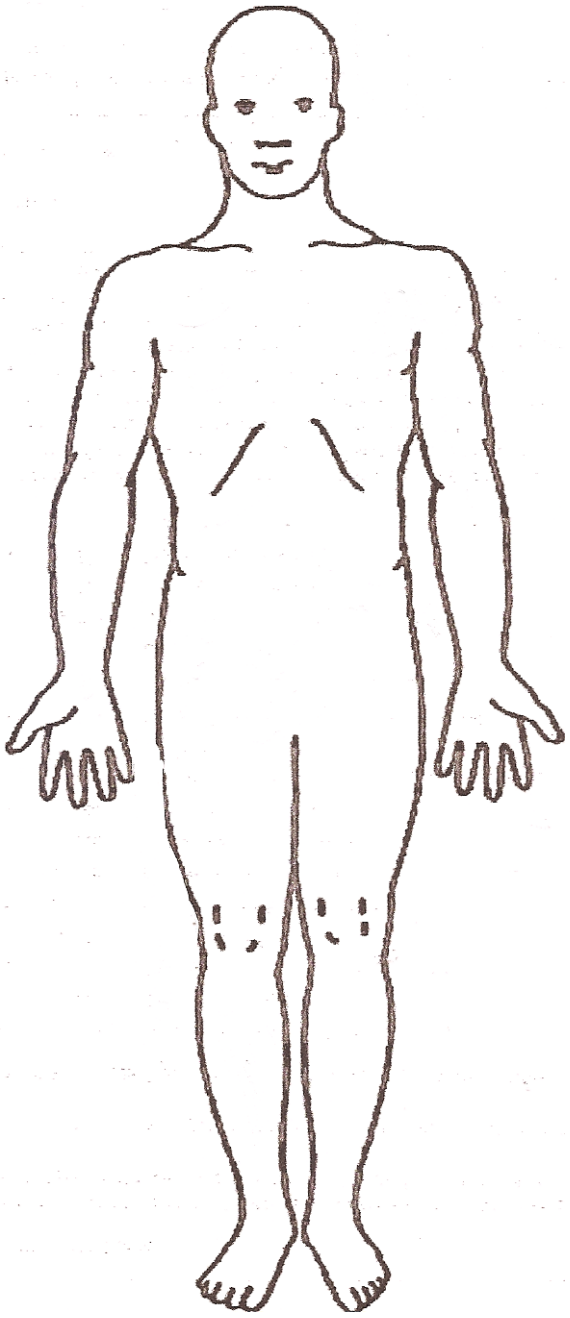
Client Signature_____Date_____

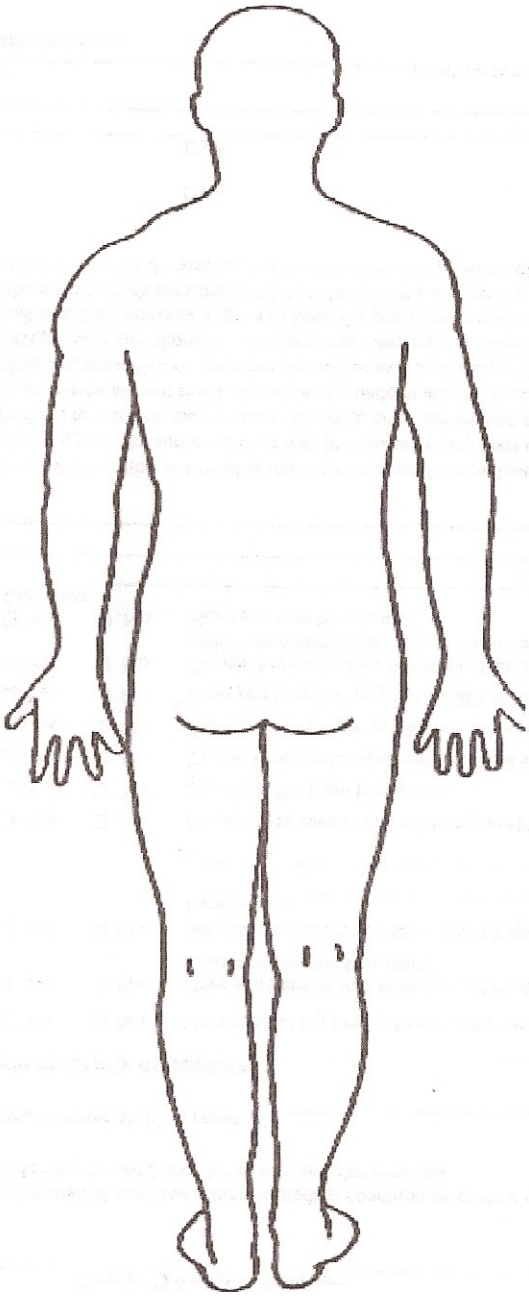
Practitioner Signature _____Date_____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____/_____/_____

Date _____/_____/_____





Legend

PPP– Area(s) where you are experiencing pain.
XXX– Area(s) that are tight
TTT– Area(s) that are ticklish.