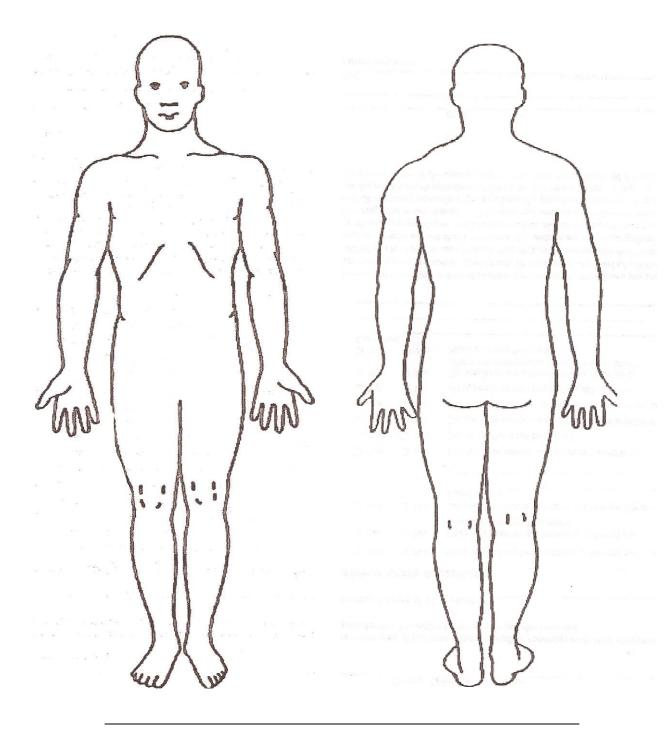
Massage Release Form

-Mandatory by Oklahoma State Law-

Name:		Occupation:
Age:	Male Female Physicia	nn
condition or prior to serv	specific symptoms, massage may be contraindicibe being provided.	ation and sign where indicated. If you have a specific medical cated. A referral from your primary care provider may be require odywork session? How recently?
	If you answer "yes" to any of the following	ng questions, please explain as clearly as possible.
YES	NO	YES NO
	Do you frequently suffer from stress?	Have you had any broken bones in the past two years?
	Do you have diabetes?	Have you been in an accident in the past two years?
	Do you experience frequent headaches?	Do you have cardiac or circulatory problems?
	Are you pregnant?	Do you suffer from back pain?
	If so, are you past your 1st trimester?	Do you have numbness or stabbing pains?
	Do you suffer from arthritis?	Are you sensitive to pressure anywhere?
	Are you wearing contact lenses?	Have you had surgery?
	Are you wearing dentures?	Do you have tension or soreness in a specific area?
	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 have any other medical condition or taking medicine that I should know about?
	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?	
perience pay be adjusted lical condition the practite etitioner's pay	in or discomfort during this session, I will immed to my level of comfort. I further understand the ons; I affirm that I have stated all my known medioner updated as to any changes in my medical part should I fail to do so. I also understand that a	or the basic purpose of relaxation and relief of muscular tension. diately inform the practitioner so that the pressure and or strokes at massage or bodywork should not be performed under certain dical conditions, and answered all questions honestly. I agree to profile and understand that there shall be no liability on the my illicit or sexually suggestive remarks or advances made by me table for payment of the scheduled appointment.
ent Signatur	e	Date
ctitioner Sig	nature	Date
Cons	ent to Treatment of Minor: By my signature belo	ow, I hereby authorize to
admi	mister massage, bodywork or somatic therapy tec	chniques to my child or dependent as they deem necessary.
G:	uture 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.