Chair Massage Intake and Release Form

Name____ Date____________________

Please circle any condition below that applies to you:

Easy Bruising Osteoporosis Heart Condition Phlebitis

Cancer Diabetes Back Problems/Spine/Disc

Arthritis Numbness Tingling Neck Problems

High Blood Pressure Low Blood Pressure Auto Immune Disease

Stroke Sprains/Strains Recent Surgeries Blood Clots

Recent Injuries Artificial Joints

Pregnancy- How many months_________

Other____

Briefly explain any condition circled_____________________________________

Medications____

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I____(Print Name) understand that the chair massage I am receiving is for basic relaxation and relief of muscular tension. If I experience any pain or discomfort I will let the therapist know immediately. I acknowledge that massage is not a substitute for medical treatment and that I should seek professional medical advice for any medical condition I am aware of. Because massage should not be performed under certain medical conditions I affirm I have stated all know medical conditions and answered all questions honestly and that the therapists bears no liability should I fail to do so. I also understand that the therapist reserves the right to refuse massage on anyone he/she deems to have a condition(s) for which massage is contraindicated. I acknowledge it is my choice to receive a chair massage. In consideration for this I do hereby discharge and release the therapists from any and all causes of action, suits, debts, claims and liability from any liability from any injuries or conditions that may occur as result of chair massage. I acknowledge that I have read and understand this release.

Client Signature________________________________ Date_______

Therapist Signature_____________________________ Date_______