

Temporomandibular Joint (TMJ) Informed Consent

Name _____

Date _____

1. A proper diagnosis regarding head and neck pain is very important because serious medical problems can be present that produce TMJ symptoms. It is recommended that you consult your physician and/ or dentist for medical diagnosis to determine if there are any underlying medical conditions resulting in TMJ symptoms.
2. I acknowledge that the massage therapist can not diagnose TMJ or any other medical/dental conditions. I acknowledge that only my physician or dentist can diagnose TMJ or any other medical condition.
3. TMJ massage therapy treatments may vary according to the complexity of your condition. Although symptoms generally respond well to treatment, general health, stress, diet, occupational complications, sports / exercise activities, etc can affect the outcome and management of the symptoms.
4. As with any therapy, unusual occurrences can and do happen. These possibilities could include but are not limited to: tooth injury, jaw injury, headache, ear pain, neck pain, loss of range of motion, muscle spasm, head and neck pain, etc. I agree to take the risks as outlined, as well as, other resulting circumstance risk from the therapy.
5. I agree to communicate with the therapist about my pain, comfort level and desire to continue treatment. I acknowledge that I am responsible to communicate if I am in pain, uncomfortable or desire for treatment to be paused or terminated at anytime.
6. I consent to have Temporomandibular Joint (TMJ) Massage Therapy treatment performed by _____ a licensed massage therapist.
7. I have NOT had Botox in the past 7-10 days. I am aware that having Botox and (TMJ) Massage Therapy treatment with 7-10 days of each other can cause Botox to travel to other non-targeted muscles.

Patient Signature (Parent or Legal Guardian if under 18)

Date

(Minors under the age of 18 must be accompanied by a parent or guardian. The parent or guardian must consent to treatment)