TRI · PHYSICAL THERAPY
PHYSICAL THERAPY | PILATES | MASSAGE

Massage Waiver of Liability and Informed Consent Release

Personal Information:

Full Name_____Cell:_____Work/Home:_____
Address_____
City/State/Zip_____
Email_____ Date of Birth_____/_____/_____Occupation_____

Emergency Contact_____Relationship_____Phone_____

The following information will be used to help plan safe and effective massage sessions at Tri-Physical Therapy. Please answer the questions to the best of your knowledge.

Date of Initial Massage Visit_____/_____/_____

1. Have you had a professional/medical massage before? Yes No
   If yes, how often do you receive massage therapy/Myotherapy?_____

2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain_____

3. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain_____

4. Do you have sensitive skin? Yes No

5. Are you wearing: contact lenses ☐ dentures ☐ a hearing aid ☐

6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please explain_____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please explain_____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, how do you think it has affected your health?
   Muscle tension ☐ Anxiety ☐ Insomnia ☐ Irritability ☐ Other:_____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
   If yes, please identify_____

10. What are your goals for this massage/Myotherapy session?
    Please explain_____

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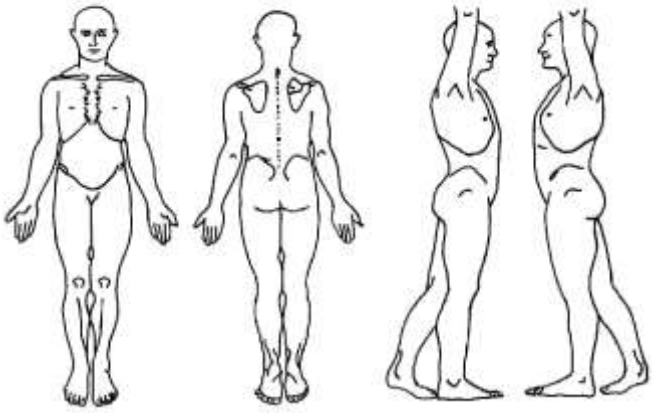
On the provided drawing, please circle any specific areas you would like the Massage Therapist to concentrate on during the session:



11. Please check any condition listed below that applies to you:

- ☐ contagious skin condition
- ☐ open sores or wounds
- ☐ easy bruising
- ☐ recent accident or injury
- ☐ recent fracture
- ☐ recent surgery
- ☐ artificial joint
- ☐ sprains/strains
- ☐ current fever
- ☐ swollen glands
- ☐ allergies/sensitivity
- ☐ heart condition
- ☐ high or low blood pressure
- ☐ circulatory disorder
- ☐ varicose veins
- ☐ atherosclerosis
- ☐ phlebitis
- ☐ deep vein thrombosis/blood clots
- ☐ joint disorder/RA/osteoarthritis/tendonitis
- ☐ osteoporosis
- ☐ epilepsy
- ☐ headaches/migraines
- ☐ cancer
- ☐ diabetes
- ☐ decreased sensation
- ☐ back/neck/problems
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ carpal tunnel syndrome
- ☐ tennis elbow
- ☐ pregnancy if yes, how many months? _____

Please explain any condition that you have marked above_____
_____

12. Are you currently taking any medication? Yes No
If yes, please list:_____

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The purpose of this page is to clarify your financial responsibilities so that we focus our efforts on helping you achieve your optimal results in the shortest amount of time.

* **Our office requires 24-hour notice cancellation of appointments.** Appointments missed or cancelled without 24 hour notice, will be charged a **$40.00 fee**.

Late Arrivals If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start/provide a treatment. Regardless of the length of the treatment provided, you will be responsible for "full cost" of the cost of session. Out of respect and consideration for your therapist and other patients/clients, please plan accordingly and be on time.

This is a Therapeutic/Medical Massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she deems necessary. _____(Initials). Male and female genitalia and women's breasts will not be exposed or touched at any time.

Informed written consent must be provided by a parent or legal guardian for any client under the age of 17 (see receptionist for waiver).

I,_____ (print name) understand that the massage/Myotherapy I receive at Tri-Physical Therapy is provided for relief of muscular tension, increase blood flow, decreasing overall pain, and improving flexibility. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy/Myotherapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a medical physician. I understand that massage therapists are not qualified to diagnose, 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Patient Signature_____**Date**_____

Patient Printed Name_____**Date**_____

Licensed Massage Therapist_____**Date**_____