Myofascial Clinic of Beaumont, Texas Craig Connors, Owner/Therapist
POLICY, PROCEDURES, AND LIABILITY WAIVER

The Massage Nerd – Waiver of Liability

DATE: _____

Name _____

Address _____

Phone Email _____

Emergency Contact (name and phone) _____

Prior Surgeries _____

Allergies _____

I, _____, release The Massage Nerd, its employees, contractors, owners, therapists, agents, and/or assigns from any responsibility and/or liability concerning the application, processing, and/or consequences of any treatment and/or procedures in which I elected to participate. I consent to having massage and therapeutic services as agreed on between myself and the therapist.

Understanding the risks of therapy. I release _The Massage Nerd, its employees, contractors, owners, therapists, agents, and/or assigns harmless against any and all liability, damage, and/or expenses arising out of or in connection with actions, claims, and/or damages resulting in personal injuries and disabilities (physical and/or psychological) or transmission of a communicable disease that might incur as a result of the service provided today and I agree to voluntarily participate understanding these risks and their outcomes. I agree that by signing this waiver, this waiver is in good standing and effective until I issue a written request for its withdrawal.

I, _____, also affirm that understanding the above-described activities that I am healthy enough to participate and hereby declare that I am at least 18 years of age. I have read the Policy, Procedures and Liability Waiver and, having no questions or concerns and being in full cooperation with these, do hereby affix my signature.

Client: _____
Signature Print Name Date

Professional: _____
Signature Print Name Date

Massage Assessment Form

Client Name: _____ Assessment Date: _____

Chief Complaint: _____ Date of Onset: _____

Brief Description of Onset: _____

Since onset, symptoms have been getting: ☐ Better ☐ Worse ☐ Staying the Same

Current Pain (0-10): ___/10 Pain range during *past 3 days*: ___/10 (at best), to ___/10 (at worst)

Pain or symptoms are: ☐ Constant ☐ Intermittent

Description of pain: ☐ Sharp ☐ Aching ☐ Stabbing ☐ Shooting
☐ Dull ☐ Burning ☐ Throbbing ☐ Other: _____

What *increases* client's pain or other symptoms, and makes condition *worse*? (Mark all that apply)

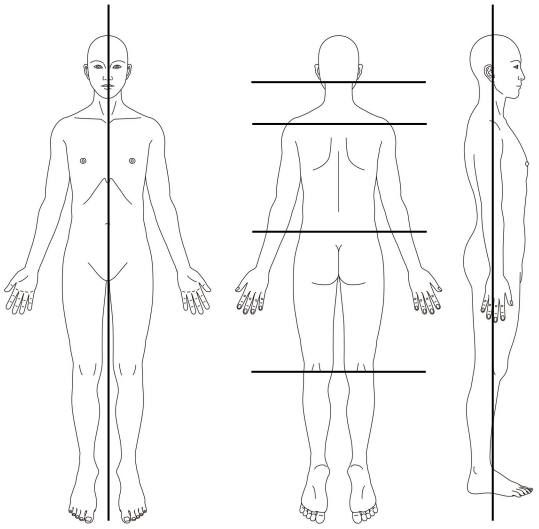
☐ Sitting	☐ Walking	☐ Coughing	☐ Specific position: _____
☐ Standing	☐ Bending	☐ Exertion	☐ Activity or movement: _____
☐ Lying down	☐ Reaching	Pressure	Other: _____
		☐	☐

What *decreases* client's pain or other symptoms, and makes condition *better*? (Mark all that apply)

☐ Sitting	☐ Rest	☐ Massage	☐ Specific position: _____
☐ Standing	☐ Ice	☐ Stretching	☐ Activity or movement: _____
☐ Lying down	☐ Heat	Medication	Other: _____
		☐	☐

Has client seen other healthcare providers or tried other treatments for current problem? ☐ yes ☐ no

List treatments and results: _____



Visual Assessment

Note

Postu

Movement/

Gai

Pain Tender point Adhesion Elevation

Hypertonicity Trigger point Swelling Rotation