WAIVER OF LIABILITY AND INDEMNITY PLEASE READ AND SIGN

Name:		Date of Birth:
Gender:	Address:	
Email:		Phone Number:

I, _____ verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential, except that such information may be used by HANNA WELLNESS STUDIO for statistical analysis or scientific purposes.

I understand that the massage treatment(s) that I receive is/are provided for the purpose of relaxation, relief of stress, muscular tension, pain, and to aid the body with its natural healing process. A massage therapist works soft tissue and may integrate gentle range of motion exercises to the joints but will not administer spinal manipulations. If I experience any pain or discomfort during the treatment, I will immediately inform the therapist so that she can adjust her techniques and pressure to within my level of comfort.

I am also informed that I have the right to stop massage treatment at any time. I further understand that massage is not a substitute for medical examinations or diagnosis and so I should seek a physician or other health professional should I need aid with mental if physical ailments.

I agree that all of the information that I have provided in my health history form is current and accurate. I acknowledge that to ensure appropriate treatment it is of upmost importance to inform my massage therapist of any old, current, or new injuries as well as inform them of any changes in my health status, or and concerns I may have.

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I am aware that on rare occasion massage therapy may cause delayed onset muscle soreness.

I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

I acknowledge that I have read, and understand, the release and indemnification provisions set forth in the preceding paragraph and agree to such terms. l hereby gives my consent to receive massage services and/or other bodywork or treatment (the "Services") from HANNA WELLNESS STUDIO, and I acknowledge and agree that I am doing so at my own risk. My health and safety with respect to such Services are my sole responsibility. I acknowledge that my receipt of the Services from HANNA WELLNESS STUDIO may result in bodily injury to me or my death. My decision to receive Services from HANNA WELLNESS STUDIO is voluntary, and I know of, understand, and assume any and all the risks associated therewith.

In exchange for receiving Services from HANNA WELLNESS STUDIO, I, for myself and on behalf of my heirs, executors, administrators, and personal representatives, hereby waive, release, discharge and hold harmless HANNA WELLNESS STUDIO, its members, officers, employees, and agents from any and all liability for any and all injuries, including death, damages or claims relating to or resulting from my receipt of the Services, now or in the future, foreseen or unforeseen. Further, I will indemnify and hold HANNA WELLNESS STUDIO, its members, officers, agents, and employees, harmless from and against any and all claims, rights, damages, liabilities, losses, costs and expenses (including reasonable attorneys' fees) arising from or in connection with any injuries to other persons or damage to property caused by or attributed to me.

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List any medications or allergies: _____

List any and all surgeries, illnesses or injuries (ortho) that you have had or have: _____

When was your last physical checkup? _____

PLEASE APPLY CHECK MARK IF IT APPLIES TO YOUR HEALTH ISSUES

Any heart/vascular problems:
_____Heart disease, heart attack, angina
_____Coronary angioplasty/cardiac surgery
_____Rapid heartbeats/palpitations
_____Heart murmurs or unusual cardiac findings
_____Peripheral vascular disease
_____Stroke
_____Other

Any metabolic disease:
_____kidney disease
_____thyroid disorders
_____liver disorders

Any respiratory disease:
_____Asthma
_____Chronic bronchitis
_____Emphysema
_____Other

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OTHER CONDITIONS:

Do you have a tendency to bruise easily? _____
Have you recently been exposed to a communicable disease?_____
Any shortness of breath_____
Unusual fatigue_____
Ankle swelling_____
Chest discomfort at rest or during exertion_____
Faint or dizziness _____
Concussion _____
Loss of consciousness/fainting for any reason_____
Neurological and epilepsy diseases_____
Acute pain in the back without diagnosis_____
Neuralgic and hernia_____
Progressive muscular dystrophy_____
Varicose veins_____
Untreated hypertension_____
Bleeding disorders_____
Cardiac arrhythmias_____
Cancer_____
Severe forms of diabetes mellitus_____
Acute arthritis_____
Electric implants_____
Pacemaker_____
A diagnosis of/treatment for high blood pressure (BP), or a resting BP of 160/90 mmhg or higher_____
A diagnosis of/treatment for heart disease or stroke, or pain/discomfort/pressure in your chest during activities of daily living or during physical activity _____
Pregnancy_____

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IF YOU HAVE ANSWERED "YES" TO ONE OR MORE OF THE ABOVE QUESTIONS, CONSULT YOUR PHYSICIAN BEFORE ENGAGING IN MASSAGE THERAPY. TELL YOUR PHYSICIAN WHICH QUESTIONS YOU ANSWERED "YES" TO. AFTER A MEDICAL EVALUATION, SEEK ADVICE FROM YOUR PHYSICIAN ON WHAT TYPE OF MASSAGE THERAPY IS SUITABLE FOR YOUR CURRENT CONDITION.

AS EXPRESS ADDITIONAL CONSIDERATION FOR THE SERVICES PROVIDED, THIS AGREEMENT AND RELEASE I HEREBY WAIVE ANY RIGHT TO TRIAL BY JURY OF ANY CLAIM, DEMAND, ACTION, CAUSE OF ACTION, SUIT, OR PROCEEDING, WHETHER IN CONTRACT OR TORT ARISING OUT OF OR IN ANY WAY CONNECTED WITH, RELATED TO OR INCIDENTAL TO THE SERVICES PROVIDED BY THE HANNA WELLNESS STUDIO. I AGREE AND CONSENT THAT ANY SUCH CLAIM, DEMAND, ACTION, CAUSE OF ACTION, SUIT OR PROCEEDING SHALL BE DECIDED BY BINDING ARBITRATION, AND THAT ANY PARTY MAY FILE AN ORIGINAL, COUNTERPART OR COPY OF THIS AGREEMENT WITH ANY COURT AS WRITTEN EVIDENCE OF MY CONSENT TO WAIVE MY RIGHT TO TRIAL BY JURY.

I VERIFY THAT ALL INFORMATION NOTES ABOVE ARE ACCURATE.
I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO UPDATE THE STAFF OF HANNA WELLNESS STUDIO OF ANY CHANGES IN MY MEDICAL STATUS AND IT IS ALSO MY RESPONSIBILITY TO OBTAIN MEDICAL CLEARANCE FROM MY PHYSICIAN BEFORE SEEKING MASSAGE THERAPY.

_____ _____

Signature of Participant Date