

## Chair Massage Consent and Release Form

Name \_\_\_\_\_ Phone \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Have you ever had massage before? ☐ Yes ☐ No

What pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Do you have any medical conditions, or have you recently had an injury or surgery that could be affected by today's massage session? ☐ Yes ☐ No *If yes, please explain:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently under a physician's supervision for this condition/injury/surgery? ☐ Yes ☐ No

*If yes, please explain:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any medications for this condition/injury/surgery? ☐ Yes ☐ No

*If yes, please explain:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Client's Consent and Release:

Massage should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions and have answered all questions. I understand that there shall be no liability on the practitioner's part for the aggravation of conditions that were present, but not disclosed, at the time of signing and which may be affected by the massage session. I understand that I will be receiving massage therapy as an adjunct form of healthcare only and that this session is not a substitute for medical examination, diagnosis or treatment. I release the massage therapy of all liability for any harm that may unintentionally occur during my treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### *For practitioner use only:*

☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 30 minute massage

☐ effleurage ☐ petrissage ☐ elbow trigger point ☐ arm glides ☐ tapotement

☐ scalp ☐ suboccipitals ☐ scalenes ☐ levator scapula ☐ trapezius ☐ rhomboids ☐ teres ☐ erectors ☐ latissimus dorsi

☐ quadratus lumborum ☐ gluteus medius ☐ deltoids ☐ forearm extensors ☐ hands

Practitioner Signature: \_\_\_\_\_