LIGHTWAY HEALING THERAPEUTIC MASSAGE, LLC
THERAPEUTIC ROOM INFORMED CONSENT AND LIABILITY RELEASE

Please check all that apply to you. If you check any, please explain below.

	Pregnant		Pacemaker		Implanted Medical Device
	Heart Disease		Malignant Tumor		Osteoporosis
	Cardiac Problems		Acute Diseases		Skin Diseases
	Artificial Joints		Carpel Tunnel Syndrome		Migraines
	Asthma		Multiple Sclerosis (MS)		Allergies:
	Abnormal Blood Pressure		**Open Cuts/Sores/Bleeding** *Where?:*		**Swollen/Inflamed** *Where?:*
	Poor Circulation				
	Soft Tissue Disorders		Apoplexia		Psychosomatic disorder
	Skin Sensitivity		**Cancer** *Where?:*		**Numbness** *Where?:*
	Contagious Diseases				
For the Eye					
	Glaucoma or Cataracts		Wear Contacts		Retinal Detachment
	Severe Nearsightedness		LASIK/PRK surgery		Eye Injury
	Blood Cots		Deep Vein Thrombosis		Deep Thrombophebitis
	Phlebitis		Arrhythmia		Erysipelas
	Pulmonary Edema		**ANY surgeries/injuries ANYWHERE in the past 2 years?**		**ANY Other Conditions?** (List below)

For Office use only:
Head, Feet, Legs, Neck, Arms

Comments:
____
____
____
____

By signing below, you agree to the following:

- _____ I hereby voluntarily request and consent to receiving massage therapy.
- _____ I understand that the massage that I receive is for the purposes of general wellness and relaxation, stress reduction, and relief of muscular tension only.
- _____ I do not have any injuries or conditions that prevent me from receiving massage therapy. I understand the importance of informing the massage therapist/therapy technician of all medical conditions and medications that I am taking, and that there may be additional risked based on my physical condition. I have been informed of the device precautions for medical conditions and have answered truthfully.

- _____ If I experience any pain or discomfort, I will immediately inform the therapist/technician so that the pressure or devices used can be adjusted to my comfort level. I will not hold Lightway Healing Therapeutic Massage or its staff responsible for any pain or discomfort I experience during or after the session. I have been shown how to power off each device.

- _____ I will not hold Lightway Healing Therapeutic Massage, LLC. or its staff responsible for the malfunction of any device or massage chair.

- _____ I am physically capable of getting on and off the massage chair/table safely.

- ______ I understand the risks associated with massage therapy and the massage devices include, but are not limited to:

    - Superficial bruising
    - Short-term muscle soreness
    - Exacerbation of undiscovered injury

- _____ I have not received a positive test for corona virus within the past 14 days, and currently have no symptoms.

- _____ I do not have any contagious condition that may put the massage therapist/therapy technician or other clients at risk.

- _____ I understand that I or the massage therapist/therapy technician may terminate the session at any time.

- _____ I have been given the opportunity to ask questions about massage therapy and the device(s) used and my questions have been answered.

- _____ I hereby consent to and permit emergency treatment in the event of injury or illness while participating in therapeutic massage.

- _____ If I am pregnant or become pregnant or am post-natal, my signature verifies that I am not at high risk or have been advised by my physician that massage should be contraindicated.

Client's Printed Name: ____ Date: ______________

Client's Signature: ____