

**Open Hands Musculotherapy, LLC**  
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www.openhandstn.org (865) 406-2762

**Client Information and Release**

Thank you for your interest in massage, bodywork, and somatic therapies. Please fill out the information below and give your completed form to the massage practitioner.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Are you currently suffering from any ailment that could be affected by today's massage/bodywork?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

If yes, are you currently under a doctor's supervision for this ailment?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please read the following statement, then sign and date below to indicate that you have read and understand the statement.

**The practitioner whose signature appears below is not responsible for the aggravation of conditions that were present, but not disclosed, at the time of the massage and which may be affected by the massage/bodywork.**

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

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

**FOR MESSAGE THERAPIST USE ONLY**

Name: \_\_\_\_\_

PEC \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_