RELEASE! MANUAL THERAPY

Informed Consent

What is Fascial Counterstrain (FCS)? Fascial Counterstrain is a gentle technique that uses body positioning, compression and glides to shorten tissue and thus release a reflexive protective tightening of fascia within various systems of the body (arterial, lymphatic, venous, visceral, ligamentous, dural, and nervous). This will help the body restore function, providing benefits such as reduction of inflammation, pain, and muscular tension, as well as improved circulation, mobility, and relaxation.

Limitations of FCS: This technique does not diagnose medical diseases or conditions and it is not a substitute for medical examination and treatment.

Adverse Reactions to FCS: Failure to inform the therapist of all medical conditions and medications may place you at increased risk for adverse reactions. Therefore, please do not omit information regarding medical conditions and medications during the health intake interview whether verbal or on the included forms. If you should experience any discomfort during a session, immediately inform the therapist so that the treatment can be adjusted appropriately. Sometimes treatment is followed by temporary soreness, fatigue or discomfort associated with tissue toxicity and the early stages of detoxification.

Self Care After Treatment:

- Following a session, please drink at least 8 – 10 glasses of water. This will help flush out toxins which have been released into the body during treatment.
- Avoid heavy lifting, strenuous workouts and other intense physical activity for 2 – 3 days following treatment. During mindful activity you will be less likely to return to old compensatory movement patterns which are related to the condition that you are seeking to resolve.
- If you are given a home program, please adhere to the recommendations. They are designed to improve your efforts to recover from the issue(s) being addressed by the treatment.

Informed Consent: With this information, I voluntarily consent to manual therapy treatments performed at Release! Manual Therapy. I understand that these treatments do not consist of diagnosing disease or prescribing medical treatment or pharmaceuticals. Spinal manipulations are not being performed. I understand that these treatments are not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have. I state that I have accurately reported all my known physical and medical conditions as well as medications consumed. I understand that Release! Manual Therapy has given me no guarantees regarding improvement or cure of my condition and I release Release! Manual Therapy from any and all liability which may occur in connection with the procedures stated above except for failure to perform these with appropriate medical care. I understand the benefits and limitations of FCS therapy and am aware that it may cause adverse reactions in certain rare situations.

Client's Signature: ___________________________________ Date: __________

I authorize the therapist of Release! Manual Therapy to provide care to my child or dependent.

Name of Child or Dependent: ____

Parent or Guardian Signature: _______________________________________ Date: __________