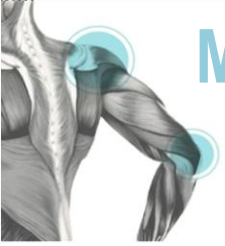

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Parent/Guardian Consent Form for Massage Therapy

The Texas Administrative Code, Title 25, Part 1, Chapter 141, Subchapter B, RULE §141.5, paragraph (b) states:

> "A registrant must obtain the written consent of a parent or guardian to provide massage therapy services to a person under the age of 17."

Minor Client's Information

Name: _____Gender: ❑ Male ❑ Female
Address: _____
City/State/Zip _____
Date of Birth: _____

Parent/Guardian Name: _____ Contact #: _____
Emergency Contact: _____ Emergency Contact Phone: _____

Parent/Guardian Statement of Consent
As parent or guardian of the above named minor, I hereby consent to said minor's therapeutic massage.

Law does not state it, I also understand that I am encouraged to remain in the treatment room during said minor's session (if under age 14 parent or guardian must be present).

I have read and agree to the above. ❑ Yes ❑ No

Parent/Guardian signature_____ Date_____

Therapist's signature _____ _____ __ Date _____

Name_____

Health History Intake
Confidential Information

Current Health

Do you exercise regularly and/or participate in any sports? . . . . . ❑ Yes ❑ No
If yes, which sports?

_____
_____.

Have you recently suffered an injury? . . . . . ❑ Yes ❑ No
If yes, describe:

_____
_____.

Have you had any areas of inflammation? . . . . . ❑ Yes ❑ No
If yes, describe:

_____
_____.

Are you currently under the care of a physician? . . . . . ❑ Yes ❑ No
If yes, explain:

_____
_____.

Have you had recent surgery? . . . . . ❑ Yes ❑ No
If yes, explain: _____
_____
_____.

MEDICAL BACKGROUND

Describe any surgeries, hospitalizations, accidents, or injuries you've had:

Less than 2 years ago: _____

More than 2 years ago: _____

Do you have any chronic, ongoing pain on a regular basis? _____

Please explain: _____

Are you currently receiving any other type of medical treatment? _____

Please list reason(s): _____

Please list any medications (vitamins, herbs, or pharmaceutical) taken now or at regular intervals (including what medication is used to treat):_____
_____

Are there any other health concerns you wish to discuss today? YES NO
If yes, please describe:

_____

I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so _____(client's initials)

Parent/Guardian signature: _____Date: _____
Therapist signature: _____ Date: _____

Health History Intake
Confidential Information

Name_____

Massage Information

Have you ever experienced a professional massage? ❑ Yes ❑ No How recently?_____ How often?_____

What type of therapy do you anticipate to receive during your session?

❑ Relaxation/Stress reduction (Swedish Massage)
❑ Breakdown Tension/Stretching/Trigger Point (Deep Tissue)
❑ Pre – Sports Events (Sports Therapy)
❑ Post- Sports Events (Sports Therapy)
❑ Injury/Chronic Pain Management (Clinical Massage)
❑ Prenatal Stretching & Relaxation (Prenatal Therapy).

Is there any chance you might be pregnant? ❑Yes ❑No
1st ❑ 2nd ❑ 3rd ❑ Trimester

Goals/expectations : _____

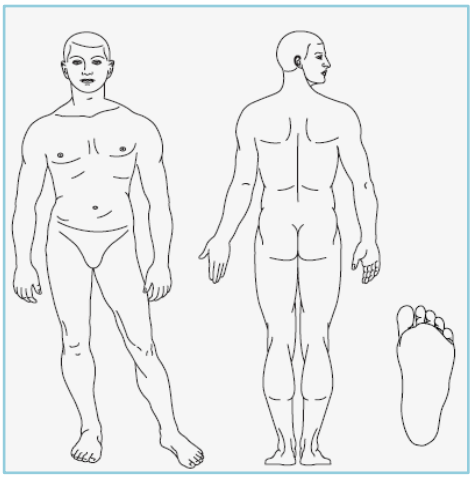
What kind of pressure do you prefer? ❑ light ❑ medium ❑ firm ❑ not sure

Please check any areas of your body that you would rather **NOT BE MASSAGED** during the session:

❑ Back ❑ Feet ❑ Legs ❑ Buttocks ❑ Hands ❑ Arms ❑ Abdomen ❑ Pecs/upper chest ❑ Neck ❑ Head ❑ Face

Do you have any of the following TODAY?

❑ Sunburn ❑ Skin Rash ❑ Open cuts, bruises, burns ❑ Inflammation ❑ Cold/Flu ❑ Strains/Sprains ❑ Severe Pain



Please indicate (X) where you experience pain on the diagram below.

Specific muscles or muscle groups you would like addressed.

_____

_____

_____

Check the following conditions that apply, both past and present.

Please add comments to clarify the condition

Musculoskeletal
❑ Headaches
❑ Joint stiffness/swelling
❑ Spasms/cramps
❑ Broken/fractured bones
❑ Strains/sprains
❑ Problems walking
❑ Jaw pain/TMJ
❑ Tendinitis
❑ Bursitis

Bone or joint disease
❑ Arthritis
❑ Osteoporosis
❑ Scoliosis

Circulatory and Respiratory
❑ Dizziness
❑ Fainting
❑ Cold feet or hands
❑ Swollen ankles
❑ Varicose veins
❑ Blood clots
❑ Stroke
❑ Heart condition
❑ Allergies
❑ Sinus problems
❑ Asthma
❑ High blood pressure
❑ Low blood pressure
❑ Lymphedema

Nervous System
❑ Numbness/tingling
❑ Twitching of face
❑ Fatigue
❑ Chronic pain
❑ Sleep disorders
❑ Ulcers
❑ Paralysis
❑ Herpes/shingles
❑ Cerebral Palsy
❑ Epilepsy
❑ Chronic Fatigue Syndrome
❑ Multiple Sclerosis ❑
❑ Muscular Dystrophy
❑ Parkinson's disease
❑ Spinal cord injury

Reproductive System
❑ Menopause
❑ Pelvic Inflammatory Disease
❑ Endometriosis
❑ Hysterectomy
❑ Prostate problems

Skin
❑ Rashes
❑ Athlete's Foo
❑ Warts
❑ Moles
❑ Acne
❑ Cosmetic sur

Other
❑ Diabetes
❑ Fibromyalgia
❑ Cancer
❑ Infectious disease (please list)
_____

❑ I have read each condition and none apply past or present

Massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. _____(client's initials)

Parent/Guardian signature: _____ Date: _____

Therapist signature: _____ Date: _____