Shelley’s Massage Consent Form

Name:____

Phone:__________________________ Cell Phone Provider : ______________

Example: At&t, Verizon

DOB:_____/______/______ Emergency Contact: ____________________________

Address:____

City:___________________________ State:________ Zip:____________________

Email:____

The Texas Administrative Code Title 25, Part 1 Chapter 140 Subchapter Rule 143,304 states that the initial constitution document is required and that it must include the following information.

1. The type of massage techniques we offer are Swedish/Relaxation Massage, Deep Tissue, Aroma Therapy, PreNatal, and Warm Stone.
2. The Massage Therapist will not perform breast massage on female clients without written consent of the client. Not offered at this time.
3. Draping will be used during the session, unless otherwise agreed to by both client and Therapist.
4. A statement that if the client is uncomfortable for any reason the client may ask the therapist to change or cease the message and the therapist will do so.
5. The parts of the client's body that will be massaged or the areas of the client's body that will be avoided during the session including indications and contraindications.

Client Medical Information

General Health:

There are certain medical conditions for which massage is contraindicated. In some cases, a doctor's release may be needed or the area can be avoided. If you are unsure if this applies to you, ask the Front Desk for a list.

List all **allergies** known to you : (Examples: Animal Protein, Foods, Aspirin, Lidocaine, Hydrocortisone, or any skin bleaching agents.) ________________________________

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced.) ____

Do you now or have you ever had a medical condition (Diabetes, Seizures, Osteoporosis, Arthritis, High Blood Pressure, Cancer, Thyroid, Blood Clotting, Skin Lesions, Contagious Disease, Cardiac or circulatory problems or any active infection) :

____

*You MUST be FREE of any contagious illness (Cold, Virus, Flu) for at **LEAST 48 HOURS***

Are you currently under the care of a physician? ____ Yes ____ No If yes, for what?_________

Are you currently:
Undergoing Chemotherapy? ____ Yes ____ No **If yes,** date of your 1st Treatment ___________

Undergoing Radiation? ____ Yes ____ No **If yes,** date of your 1st Treatment ______________

Are you **Pregnant** or trying to become pregnant? ____ Yes ____ No

If you are PREGNANT how many weeks are you? __________________ For you and your baby's safety we do not recommend having a massage until after your 1st Trimester!!

Are you breastfeeding? ____ Yes ____ No
In the last 2 years have you had any broken bones or injuries?___________________________
Do you have any stiffness or soreness? ____Yes____No **If Yes, Explain** ___________________

Medications:

Do you take any medications for heart conditions? _____________________________________

What topical medications or creams are you currently using ?____________________________

What oral prescription medications are you currently taking?____________________________

- I consent to the use of my before, during and after massage procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval.
  ______ Yes ______ No
- I am over **18 years of age** or I have parental consent. ______ Yes ______No
- I consent to **todays and/or future** massage modalities (deep tissue, cupping, aroma therapy, and lomi lomi).

I am aware that the therapist doesn't diagnose illness or disease or prescribe medications.
I understand that massage therapy isn't a substitute for medical treatment. I also understand that massage therapy is not used for sexual therapy.
Please sign below to acknowledge all information is true and correct.

Guest Signature:__________________________________Date:________________________

Therapist Signature:_________________________________Date:______________________