OVCMT

Date: ____________________________

OVCMT Confidential Health History
Short Form for MINORS

Patient Name: _____________________ Time: ________ Student Name:

1. Have you had previous experience with therapeutic massage? Y N

2. Do you take medication regularly? Y N

3. Do you have a condition that has been diagnosed by a physician?

   (cardiovascular; respiratory; circulatory) Y N

4. Do you have any recent (in the last six weeks) injuries? Y N

5. Do you experience abnormal skin sensation? Y N

6. Do you have any skin conditions (fungus, eczema, psoriasis) Y N

7. Are you experiencing any pain or discomfort in your body right now? Y N

8. Have you taken any medication in the last 12 hours? Y N

If you answered "yes" to any of the questions above, please use the space provided to explain. This is for your own safety.

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Parent/Legal Guardian Consent for Minors

I, ______________________________ (print name) do herby give my consent for my son/daughter,

_______________________________, to receive massage from an OVCMT student.

Parent/Guardian signature: ___________________________________ Date: __________________

Telephone number where you can be reached if you will not be present: __________________________

Please ensure that your child knows that he/she is able to direct and/or stop the massage at any time, if they are feeling uncomfortable.

Please comment if you have any directions for the student therapist regarding the massage session:

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