

**This is a SAMPLE CONSULTATION DOCUMENT containing the  
ITEMS NECESSARY for State compliance.**

The items in **bold lettering** and underlined are the **minimum** which **MUST** be contained in any consultation document used to adhere to the State's basic requirements.

It is the responsibility of EVERY therapist to ensure that EACH client completes a consultation document prior to receiving services.

My Massage Consultation Document  
1234 Locust St. #101  
Austin, Texas 78701  
123-456-7890

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

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

**Are you under the age of 17? If yes, must have written consent of parent or guardian to receive massage.**

Please check below all that apply:

- Spinal Problems     Allergies     High Blood Pressure     Bruise Easily  
 Varicose Veins     Migraines     Heart Conditions     Injuries  
 Smoke     Currently Pregnant? Due Date: \_\_\_\_\_

Please explain any checked above: \_\_\_\_\_  
\_\_\_\_\_

Any medical conditions your therapist should be made aware of?

Current Medications: \_\_\_\_\_

Type of massage you are requesting (Please circle one below):

Swedish/Relaxation    Deep Tissue    Trigger Point    Pregnancy Massage    Hot Stone

Areas of pain/tension: \_\_\_\_\_

Areas to be avoided: \_\_\_\_\_

Massage therapy is not a substitute for medical examination or diagnosis. It is recommended that I see a physician for any physical ailment that I have. I understand that the massage therapist does not prescribe medical treatments or pharmaceuticals, and does not perform any spinal adjustments. I am aware that if I have any serious medical diagnosis I must provide a physician's written consent prior to services.

**The massage therapist will not perform breast massage on female clients without the written consent of the client prior to the massage session.**

**Draping will be used during the massage session unless otherwise agreed to (*Recommended: "in writing"*) by both client and therapist.**

**If uncomfortable for any reason the client (*Recommended: "or therapist"*) may ask to end the massage session, and the session will be ended.**

***To be completed by therapist:***

**Type of Massage Technique to be implemented:**

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**Parts of the body to be massaged (Including indications and contraindications):**

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**Client signature:**

**Date:**

**(Parent or Guardian if under the age of 17)**

**Therapist signature:**

**Date:**