



SCHOOL OF MASSAGE THERAPY  
Lake View Building  
600 Pine Forest Drive Ste#120  
Maumelle, AR 72113  
(501) 851-1422  
www.auoha.com

Dear Applicant,

Thank you for your interest in the American University of Healing Arts (AUOHA) Professional Training Program in massage therapy.

The enclosed Application Packet includes the following:

- < **Health History**: Complete both forms and sign.
- < **Two (2) Personal References**: To be completed by colleagues, employers, or associates (no family members please).
- < **Physician's Statement**: Information regarding content is defined on enclosed form.
- < **Statement of Purpose**: Please complete.

Additional materials we ask you to submit with your application are:

- < **A valid copy of your Driver's License and Social Security Card**
- < **A high school diploma, GED, or College Transcript**
- < **A negative TB skin test**

*All of the above information must be completed and returned to AUOHA before any student will be allowed to begin classes.*

The Admissions Committee reviews the applications. Applicants should:

- < meet all requirements;
- < have no contraindications for giving or receiving massage;
- < have experience and familiarity with massage;
- < be aware of personal growth and development;
- < understand and accept AUHA's philosophy, approach and ethics; and
- < be able to meet the time requirement and financial demands of the program.

If you have little experience with massage, we suggest you gain some before applying. If you have questions about whether or not your experience would suffice or regarding the application process, please call.

Thank you for your interest. I look forward to receiving your application.

Sincerely,

A handwritten signature in black ink that reads 'Tina R. Sharif'.

Tina Sharif  
Director



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## ***APPLICANT HEALTH HISTORY***

Today's Date: \_\_\_\_\_

Applicant's Name \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have you received a professional massage or any other form of body work?  Yes  No  
 If so, what type(s)? \_\_\_\_\_

§ Please list the health practitioners (medical, mental health, physical therapy, acupuncture, chiropractic, etc.) that are currently treating you:

Practitioner's Name	Type of Treatment	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

§ What are your current goals, in seeking care? \_\_\_\_\_  
 \_\_\_\_\_

§ What joint problems, surgeries, injuries or mental or physical illnesses to you or have you had? How do these affect you currently?  
 \_\_\_\_\_  
 \_\_\_\_\_

§ Please list any medications you are taking, and the condition(s) they are prescribed to treat.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Do they control the condition(s)? \_\_\_\_\_  
 What side effects, if any, do you experience; \_\_\_\_\_

- § Do you use recreational drugs?  Yes  No
- § Do you smoke?  Yes  No
- § Do you use alcohol?  Yes  No If so, how often?
- § Do you have allergies?  Yes  No If so, to what?
- § Are you pregnant?  Yes  No
- § Do you wear contact lens?  Yes  No
- § What kinds of exercise to you do regularly? \_\_\_\_\_

Please **CIRCLE** any of the conditions listed below that you currently have or have had in the past, and indicate the dates in the space to the right.

**Systemic Infections:** Mononucleosis\_\_\_\_\_ T.B.\_\_\_\_\_ Flu\_\_\_\_\_ Hepatitis\_\_\_\_\_ Fever\_\_\_\_\_ Other\_\_\_\_\_

**Cardiovascular:** Heart Attack\_\_\_\_\_ Heart Disease\_\_\_\_\_ High/Low Blood Pressure\_\_\_\_\_ Varicose Veins\_\_\_\_\_ Phlebitis\_\_\_\_\_ Stroke\_\_\_\_\_ Blood Clots\_\_\_\_\_ Acute Inflammation\_\_\_\_\_ Other\_\_\_\_\_

**Musculoskeletal:** Whiplash\_\_\_\_\_ Back Pain\_\_\_\_\_ Sprain\_\_\_\_\_ Fracture\_\_\_\_\_ Foot Pain\_\_\_\_\_ Scoliosis\_\_\_\_\_ Osteoporosis\_\_\_\_\_ Rheumatoid Arthritis\_\_\_\_\_ Osteoarthritis\_\_\_\_\_ Sports Injuries\_\_\_\_\_ Torn Ligaments/Cartilage/Tendons\_\_\_\_\_ Other\_\_\_\_\_

**Neurological:** Sciatica\_\_\_\_\_ Headaches\_\_\_\_\_ Slipped Disk\_\_\_\_\_ Multiple Sclerosis\_\_\_\_\_ Tingling/Numbness/Weakness/coldness in Limbs\_\_\_\_\_ Other\_\_\_\_\_

**Skin Infections:** Scabies\_\_\_\_\_ Lice\_\_\_\_\_ Herpes I\_\_\_\_\_ Herpes II\_\_\_\_\_ Eczema\_\_\_\_\_ Burns\_\_\_\_\_ Ringworm\_\_\_\_\_ Athlete's Foot\_\_\_\_\_ Warts\_\_\_\_\_ Other\_\_\_\_\_

**Endocrine:** Diabetes\_\_\_\_\_ Hypoglycemia\_\_\_\_\_ Other\_\_\_\_\_

**Respiratory:** Emphysema\_\_\_\_\_ Hay Fever\_\_\_\_\_ Asthma\_\_\_\_\_ Sinusitis\_\_\_\_\_ Pneumonia\_\_\_\_\_ Pleurisy\_\_\_\_\_ Other\_\_\_\_\_

**Reproductive:** Menstrual Cramps\_\_\_\_\_ PMS\_\_\_\_\_ Prostatitis\_\_\_\_\_ Endometriosis\_\_\_\_\_ Other\_\_\_\_\_

**Urinary:** Urinary Tract Infections\_\_\_\_\_ Frequent Urination\_\_\_\_\_ Difficult or Painful Urination\_\_\_\_\_ Other\_\_\_\_\_

**Psychological:** Mood Swings\_\_\_\_\_ Sleep Disorders\_\_\_\_\_ Exhaustion\_\_\_\_\_ Depression\_\_\_\_\_ Acute\_\_\_\_\_ Anxiety\_\_\_\_\_ Other\_\_\_\_\_

**Cancer:** Please Describe: \_\_\_\_\_  
Dates: \_\_\_\_\_

**Surgery:** Please Describe: \_\_\_\_\_  
Dates: \_\_\_\_\_

**Miscellaneous:** Please Describe: \_\_\_\_\_  
Dates: \_\_\_\_\_

I affirm that the above information is true, accurate and current to the best of my knowledge.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date



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## ***APPLICANT PERSONAL REFERENCE FORM***

Name of Applicant:

Name of Reference:

This applicant has applied to study massage in the American University of Healing Arts School of Massage Therapy Professional Training Program. We would appreciate your thoughtful assessment of this applicant's potential to succeed in the program.

Please complete this form and return it to the applicant or mail it to the attention of the Director at the address listed below. Thank you.

1. How long have you known this person?
2. In what capacity do you know this person? (Friend, business, professional, neighbor, etc.)
3. What experience, if any, have you had with massage?
4. How would you rate this applicant's integrity and dependability?
5. Does he or she get along well with other people?
2. How would you describe this applicant's communication skills?
3. How would you describe this applicant's academic skills?
4. Please state any reasons why AUHA should or should not accept this person into the Professional Training Program.
5. Additional comments (use back of page if needed):

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Signature

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Date

---

Address

---

Phone Number



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Signature

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Date

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Address

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Phone Number



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Dear Physician of \_\_\_\_\_:  
(Student's Name)

In order for the American University of Healing Arts School of Massage to maintain the highest quality of professionalism, we require each student to obtain a statement from a physician approving enrollment.

Please send us a statement on your letterhead that your patient is free from any physical (contagious, infectious, communicable diseases), mental or emotional problems that would preclude him or her from entering course work to become a licensed massage therapist.

Thank you.

Sincerely,

A handwritten signature in black ink on a light-colored background, reading 'Tina B. Sharif'.

Tina Sharif  
Director



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## ***STATEMENT OF PURPOSE***

Please state why you want to study massage therapy. Include any personal growth and/or bodywork experiences which have contributed to your decision to begin this training.