Name: _____ Date: _____

Telephone # (day) _____ (cell) _____ Date of Birth: _____

Address: _____

Email address: _____

1. Have you had Massage Therapy before? ❑ **YES** ❑ **NO** If yes, was there anything you liked or didn't like?

_____

_____

2. What kind of activities are you able to participate in?

_____

Please give a general idea of your current day−to−day or week−to−week activates, if any.

_____

_____

3. When were you first diagnosed with cancer? _____ What type of cancer? _____

Is the cancer currently active? _____ Where was / is it located _____

4. Are you being treated now? ❑ **YES** ❑ **NO** If no, what was the date of your last treatment? _____

NOTE: If you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of the massage session, please have your physician complete the MD permission form.

5. What **treatments** have you undergone, when? **Please list dates and types of surgery and other treatments.**

_____

_____

6. Current **medications** (for cancer or other conditions):

_____

_____

_____

7. Did your treatment include any removal or radiation of lymph nodes? **(If yes, please describe where)**

_____

8. Did your treatment include radiation therapy? **(If yes, please describe where)**

_____

9. Do you have any **site restrictions** due to: **(please check all that apply)**

❑ incisions, open wounds, drains or dressings ❑ IV, port, ostomy, catheter, or other device (circle) ❑ neuropathy
❑ skin sensitivity, rash, or skin condition ❑ fracture history ❑ radiation site ❑ a tumor site
❑ bone or spine metastasis ❑ area of infection ❑ history/risk of blood clot
❑ other **(please describe below)**_____

_____

10. Do you have any pressure restrictions due to: **(please check all that apply)**

❑ history or risk of lymphedema **(circle which)** ❑ anticoagulants ❑ low platelet count ❑ fatigue
❑ bone or spine metastasis ❑ steroid medication ❑ fragile veins ❑ recent surgery ❑ infection or fever
❑ area of pain or burning ❑ other **(please describe below)** _____

_____

11. Do you have any position restrictions due to: **(please check all that apply)**

❑ incision ❑ medication ❑ ostomy ❑ tumor site ❑ difficulty breathing ❑ tender skin
❑ swelling or risk of swelling (any specific body area need elevating?)

Please describe _____

_____

❑ medical devices **please describe** _____

❑ discomfort **please describe** _____

12. Has cancer or cancer treatment affected any of the following functions in your body? **(please check all that apply)**

❑ Lungs ❑ Liver ❑ Nervous system ❑ Heart ❑ Kidney ❑ Blood count ❑ Energy level

Circle any that you are currently experiencing and describe _____

General Signs and Symptoms

Check "yes" and add comments if you have or have had any of the following:	**Yes**	**No**	**Comments**
13. Any **swelling** or **tendency to swell** anywhere in your body?			
14. Any sites of **pain** or **tenderness** anywhere in your body?			
15. Any sites of **numbness** or **reduced sensation** anywhere in your body?			
16. Any areas of **inflammation**?			

Other Medical Conditions

Check "yes" and comments if you have or have had any of the following:	**Yes**	**No**	**Comments**
17. **Skin conditions** (rashes, infection, itching)			
18. Known **allergies** or **sensitivities** (if you use any physician−approved or well−tolerated lotion on your skin, please bring it for us to use with you)			
19. **Cardiovascular conditions** (History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)			
20. **Liver or Kidney conditions** (for example: kidney failure, hepatitis, portal hypertension, etc.)			
21. **Respiratory or Lung conditions**			
22. **Diabetes** (describe type, any medication, whether blood sugar is well−controlled, any complications.)			
23. **Injuries** (any back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures)			
24. **Arthritis or Joint problems**			
25. **Digestive problems**			
26. **Surgery**			

Consent for massage: Please read the following statement carefully and sign where indicated.

I understand that the therapeutic massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. I understand that it is NOT meant to replace my regular medical care. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. The reasonable risks, benefits and alternatives to therapeutic massage / bodywork have been explained to me and all of my questions have been answered to my satisfaction.

Patient Signature	Printed Name	Date / Time
Parent / Guardian Signature	Printed Name	Date / Time