Cary Massage

Cancer Client Health Form

Name: _____ Date: ____ / ____ / ____

Address: _____City_____State___Zip_____

Email _____ Referred by: _____

Telephone: (_____)_____-_____ (_____)_____-_____ Date of Birth: ____/____/____
Home Other

Height: _____ Weight: _____ Gender: M / F Occupation: _____

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1. Have you received Massage Therapy before? **Yes No**

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

3. Where was/is it located? _____

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

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

6. Current medications, not described above: _____
_____

7. Did your treatment include any removal or radiation of lymph nodes? *If yes, where?*
_____

8. Did your treatment include radiation therapy? *If yes, where?* _____

9. Do you have any ***site restrictions*** due to:
___ incisions, open wounds, drains or dressings ___ skin sensitivity, rash or skin condition
___ IV, port, ostomy, catheter, or other device ___ history of risk of blood clots or phlebitis
___ a tumor site ___ radiation site ___ bone or spine metastasis
___ neuropathy ___ fracture history ___ area of infection
___other (please describe) _____

10. Do you have any ***pressure restrictions*** due to:
___ history or risk of lymphedema (circle which) ___ area of pain or burning
___ anticoagulants ___ low platelet count ___ bone or spine metastasis
___ steroid medication ___ fragile/sensitive skin ___ fragile veins
___ fatigue ___ recent surgery ___ infection or fever

11. Do you have any ***position restrictions*** due to:
___ incision ___ medication ___ostomy
___ tumor site ___difficulty breathing ___tender skin
___ swelling (or risk of) (any body area need elevating?) ***describe*** _____
___ medical devices ***please describe*** _____
___ discomfort ***please describe*** _____

12. Has cancer treated affected any of the following functions in your body?
___ Lungs ___Liver ___ Nervous System ___Heart
___Kidney ___ Blood Counts ___ Energy Level
(circle any that you are currently experiencing and describe _____)

General Signs and Symptoms

Check "yes" and add comments if you are 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 area of inflammation?			

Other Medical Conditions

Check "yes" and add comments if you have or have had any of the following:	Yes	No	Comments
17. ***Skin conditions*** (rashes, infections, itching)			
18. Known ***allergies*** or ***sensitivities*** (if you use any physician-approved lotion on your skin, please bring it for the massage therapist to use)			
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*** (i.e.: kidney failure, hepatitis, portal hypertension, etc.)			
21. ***Respiratory or Lung conditions***			
22. ***Diabetes*** (describe type, medication, whether blood sugar is well-controlled, any complications.)			
23. ***Injuries*** (any back problems, knee problems, tendonitis, disc injuries, neck problems, recent fractures)			
24. ***Arthritis or Joint problems***			
25. ***Digestive problems***			
26. ***Surgery***			

Cary Massage

Cancer Client Health Form (continued)

Please read the following and sign your name below

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioners so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist of any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioners updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in the immediate termination of the session, and I will be liable for payment of the scheduled appointment. I also understand that should the need arise for me to cancel my appointment it will be done 24 hours in advance or I will be liable for payment of the scheduled appointment.

Signature: _____ Date: _____

Parent or guardian signature (if under 18): _____