Oncology Massage Health History

Name:

DOB:

Email:

1. Have you had Massage Therapy before? **Yes** **No** If yes, was there anything you liked or did not like?

_____

2. How would you like massage to support you?
   _____

3. Is your Oncologist aware that you receive massage? **Yes** **No**

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

5. Where was/is it located?
   _____

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

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

Treatment/Dates

_____

_____

_____

8. Current medications (Please list any side effects you may have from each medication)

Medication/Side Effects

_____

_____

_____

9. Did your treatment include any removal or radiation of lymph nodes (if yes, please describe where) _____

10. Do you have any ***site restrictions*** due to:

____Incision, open wounds, drains or dressings	____Skin sensitivity, rash, or skin condition	____IV catheter	____A tumor site
____A radiation site	____Neuropathy	____Bone metastasis	____Fracture history
____Area of infection	____History/risk of blood clot	____ Medical Device	____Drain

11. Are you experiencing any of the following that would affect the massage ***pressure***:

____History or risk of lymphedema	____Area of pain	____Risk of easy bruising	____Swelling	____Infection or fever
____Fragile/sensitive skin	____Fragile bones	____Fatigue	____Recent surgery	__Anticoagulant
Other, please explain:				

12. Do you have any ***positioning needs*** due to: (please circle)

Incision Swelling Medical Device Tumor Site Discomfort Breathing Difficulty

What are your specific needs?

General Signs and Symptoms	***Y***	***N***	***Comments***
Swelling or tendency to swell anywhere on your body?			
Any sites of **pain** or **tenderness** anywhere in your body?			
Any sites of **numbness** or **reduced sensation** anywhere in your body?			
Any areas that you **protect**?			

Other Medical Conditions	***Y***	***N***	***Comments***
Skin Conditions (rashes, infections, itching)			
Known allergies or sensitivities (if you use a special lotion, feel free to bring it)			
Cardiovascular conditions (history of heart condition, high blood pressure, angina, hardening of arteries, stroke, varicose veins, blood clots			
Liver or Kidney conditions (kidney failure, hepatitis, portal hypertension, etc.)			
Respiratory or Lung conditions			
Diabetes (describe type, any medication, whether blood sugar is well controlled, any complications)			
Injuries (back, neck, hip, knee problems, tendonitis, disc injuries, recent fractures)			
Arthritis or Joint problems			
Digestive problems			

Other Medical Conditions	*Y*	*N*	*Comments*
Surgery			
Other			

By this waiver, I assume any risk and take full responsibility for my health and safety and will alert my therapist to any physical conditions I have now or may have in the future which may be contradictory to any therapy associated with Virginia L Murphy/Sacred Healing Bodyworks. I have signed this agreement freely and I am 18 years of age or older and mentally competent to enter into this waiver.
I waive any claims of personal injury associated with Virginia L Murphy/Sacred Healing Bodyworks and confirm that I understand that by signing this WAIVER AND RELEASE, I have given up considerable future legal rights.

Signature_____
Date_____