

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:

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 _____