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Name: Age: Date of Session:

1. Have you had Massage Therapy before? If yes, was there anything that you liked or didn’t like?

2. What kind of activities do you participate in? Please give us a general idea of your current day-to-day or week-to-week activities, 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? If no, what was the date of your last treatment?

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

6. Current medications (for cancer and other conditions) not described above and what they are for.

7. Did your treatment include any removal of lymph nodes? 8. Did your treatment include radiation therapy?

 If yes, where and how many? If yes, where?

9. Do you have any site restrictions due to: 10. Do you have any pressure restrictions due to:

 \_\_\_\_\_ incisions, open wounds, drains or dressings \_\_\_\_\_ history or risk of lymphedema (circle which)

 \_\_\_\_\_ skin sensitivity, rash or skin condition \_\_\_\_\_ anticoagulants

 \_\_\_\_\_ IV, port, ostomy, catheter, or other device (circle) \_\_\_\_\_ low platelet count

 \_\_\_\_\_ a tumor site \_\_\_\_\_ bone or spine metastasis

 \_\_\_\_\_ a radiation site \_\_\_\_\_ steroid medication

 \_\_\_\_\_ neuropathy \_\_\_\_\_ fragile/sensitive skin

 \_\_\_\_\_ bone or spine metastasis \_\_\_\_\_ fragile veins

 \_\_\_\_\_ fracture history \_\_\_\_\_ area of pain or burning

 \_\_\_\_\_ area of infection \_\_\_\_\_ fatigue

 \_\_\_\_\_ history/risk of blood clot \_\_\_\_\_ recent surgery

 \_\_\_\_\_ other (describe) \_\_\_\_\_ infection or fever

 \_\_\_\_\_ other (describe)

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11. Do you have any position restrictions due to:

 \_\_\_\_\_ incision \_\_\_\_\_ medication \_\_\_\_\_ ostomy \_\_\_\_\_ tumor site \_\_\_\_\_ difficulty breathing \_\_\_\_\_ tender skin

 \_\_\_\_\_ medical device \_\_\_\_\_ discomfort \_\_\_\_\_ swelling or risk of swelling \_\_\_\_\_ any body area need elevating?

**Please describe**.

12. Has cancer or cancer treatment affected any of the following functions in your body? (please circle current issues)

 \_\_\_\_\_ Lungs \_\_\_\_\_ Liver \_\_\_\_\_ Nervous System \_\_\_\_\_ Heart \_\_\_\_\_ Kidney \_\_\_\_\_ Blood Counts \_\_\_\_\_ Energy Level

**Please describe:**

**General Signs and Symptoms**

|  |  |  |  |
| --- | --- | --- | --- |
| Check Yes 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 or 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 if you have or have had any of the following. | Yes | No | Comments |
| 17. Skin conditions (rashes, infections, itching, etc …) |  |  |  |
| 18. Known allergies or sensitivities (if you use any physician-approved or well tolerated lotion on your skin, please bring it with you for us to use) |  |  |  |
| 19. Cardiovascular conditions (History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots etc…) |  |  |  |
| 20. Liver or Kidney conditions (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, etc …) |  |  |  |
| 24. Arthritis or Joint problems |  |  |  |
| 25. Digestive problems |  |  |  |
| 26. Surgery |  |  |  |