Integrative Healing Arts
Medical and Wellness Massage
www.iha-holistic.us

Brenda Dickenson, LMT

Oncology Massage Intake Form

Contact Information

Name _____

Address _____

City State Zip _____

Email Address _____

Primary phone (home/cell/work) _____

Emergency Contact _____

Contact Phone _____

Contact Relationship _____

Appointment confirmations, appointment reminders, changes to appointments or cancellations and may be sent by email or text message. Please initial here to consent to these messages: _____

Would you like to be added to my waiting/notification list? In the event I have a cancellation you may be notified by text message that an appointment time has become available. Initial here to opt in. _____

Personal Information

Date of Birth _____

Gender (optional) _____

Pronoun (optional)_____

Occupation _____

Referred by _____

Have you had a professional massage before? _____

If so, anything you liked or didn't like? _____

_____

Any difficulty laying on your stomach or back? _____

Are you sensitive to touch or pressure in any area? ____

If so, please explain_____

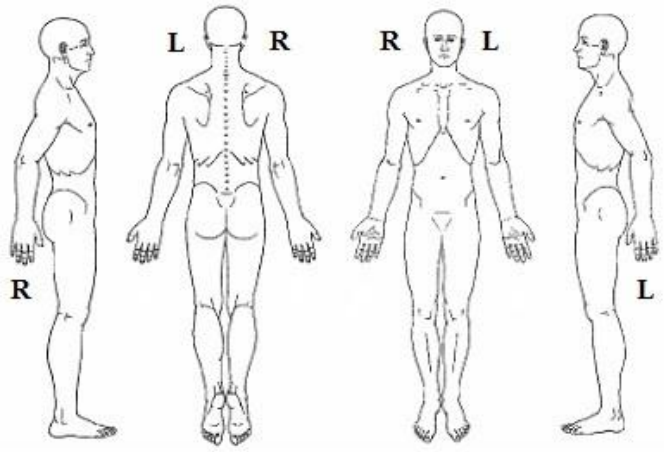
Is there anything you would like me to know about your massage goals or preferences? _____

_____

_____

_____

Please identify the areas of concern, if any, on the chart below:



Medical Information

Please indicate any of the following that apply to you.

☐	Osteoarthritis	☐	Heart Condition	☐	Anxiety / Depression
☐	Osteoporosis / Bone loss	☐	Stroke	☐	Stress
☐	Back / neck problems	☐	Blood Clots / Clotting issues	☐	PTSD
☐	Broken Bone (in last 2 years)	☐	Deep Vein Thrombosis	☐	Neuropathy
☐	Joint Replacement(s)	☐	High / Low Blood Pressure	☐	Numbness
☐	TMJ	☐	Varicose veins	☐	Carpal Tunnel Syndrome
☐	Headaches / Migraines	☐	Easy Bruising	☐	Epilepsy
☐	Rheumatoid arthritis	☐	Atherosclerosis	☐	Cancer
☐	Fibromyalgia	☐	Circulatory disorder	☐	Diabetes
☐	Autoimmune disorder	☐	Phlebitis	☐	Kidney Dysfunction
☐	Allergies / Sensitivity	☐	Tendonitis	☐	Current Fever
☐	Asthma	☐	Sprains or Strains	☐	Swollen Glands
☐	Recent surgery (in last 2 years)	☐	Recent accident of injury	☐	Open Sores / Wounds
☐	Pregnancy - if so, how far along? _____			☐	Contagious Skin Condition

Please list any other condition, or provide any details regarding indications above _____

_____

_____

_____

Have you been seriously injured, involved in a major auto or work place accident, or had surgery (for any reason) in the last 5 years? If yes, please explain:

_____

_____

_____

_____

Any major surgeries (regardless of date), any injuries or accidents older than 5 years but that you still receive care for or that have ongoing effects? If yes, please explain:

_____

_____

_____

_____

List any medications or supplements that you are currently taking as well as any side effects you are experiencing:

_____

_____

_____

Please any known list allergies or hypersensitivities:

_____

_____

_____

Oncology Related Information:

What kind of activities / exercise do you do? _____

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

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

Are you being treated now? Yes No If no, when was the date of your last treatment? _____

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

_____

_____

Did your treatment include removal or radiation of lymph nodes? Yes No If yes, please describe where.

_____

Did your treatment include radiation therapy? Yes No If yes, please describe where.

_____

Did your treatment include chemotherapy: Yes No
Number of Treatments:_____ Beginning Date:_____ End:_____
Number of Treatments:_____ Beginning Date:_____ End:_____
Number of Treatments:_____ Beginning Date:_____ End:_____

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 (circle)
☐ a tumor site ☐ radiation site
☐ bone or spine metastasis ☐fracture history
☐ area of infection ☐ history/risk of blood clot
☐ neuropathy ☐ other (describe below)

Do you have any pressure restrictions due to:

☐ history or risk of lymphedema (circle which)
☐ anticoagulants ☐low platelet count
☐ bone or spine metastasis ☐ steroid med
☐fragile/sensitive skin ☐ fragile veins
☐area of pain or burning ☐ fatigue
☐ recent surgery ☐ infection or fever
☐ other (describe below)

_____

_____

Do you have any position restrictions due to:

☐ incision ☐medication ☐ostomy ☐ tumor site ☐difficulty breathing ☐tender skin

☐ swelling or risk of swelling (any body area need elevating?) please describe: _____

☐medical devices please describe:_____

☐discomfort please describe:_____

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

☐ lungs ☐ liver ☐nervous system ☐heart ☐kidney ☐blood counts ☐energy levels

Release for Treatment

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms that may make massage therapy contraindicated, please seek a referral from your medical doctor.

By signing this, I agree that I have completed all sections of this intake form truthfully, to the best of my ability and have stated all my known medical conditions. I will inform the therapist of any changes in my medical condition and/or medications and understand that there shall be no liability on the therapist's part should I forget to do so. I understand that massage therapy is a therapeutic measure used to reduce stress, relieve muscular tension, and for pain management/elimination. If I experience any pain/discomfort during this or any other session I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my comfort level.

This is a therapeutic massage, and any sexual behavior or advances will terminate the session and I will be liable for the full payment of the scheduled treatment.

I understand that a massage should not be construed as a substitute for medical examination, diagnosis, or treatment by a physician. I further understand that massage therapists 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 treatment sessions should be construed as such. I understand that it is my responsibility to consult a physician for any ailments I may have.

I understand that all payments are due at the time of service.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

I am aware of the potential benefits and risks of massage therapy.

I agree with any terms outlined above and give my consent to receive massage therapy from Brenda Dickenson, LMT

Print Name: _____

Signature: _____ Date: _____

Integrative Healing Arts
Brenda Dickenson, LMT
COVID-19 ADD

CORONA VIRUS/COVID-19 ADDENDUM
This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

CONSENT FOR CARE

To proceed with receiving care, I confirm and understand the following (Initial in all places provided):

- I understand that COVID-19 is extremely contagious and may be contracted from various sources. I further understand that COVID-19 has an incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

- I understand that preventative measures, including the wearing of masks, and intensified hygienic and sanitation protocols intended to reduce the potential for spread of COVID-19 have been implemented. However, because the type of work being offered involves close physical proximity over an extended period of time in a closed space, there may be elevated risk. I hereby acknowledge and assume the risk and give my express permission to Brenda Dickenson, LMT to proceed with providing care. _____

- I understand that wearing a mask is optional. It is also within my right to ask the therapist to wear a mask during treatment. _____

To give your consent, read and sign below:

I knowingly and willing consent to receive massage therapy care from Brenda Dickenson, LMT understanding risks associated with receiving care during the ongoing COVID-19 health crisis. I agree to abide by all rules of the massage provider and her massage practice, as well as shared offices in the building within which it is located, as it pertains to requirements and protocols for COVID-19 both now and in the future.

Signature _____

Date _____

Integrative Healing Arts
Brenda Dickenson, LMT
Booking/Cancellation/No show Policy

Deposits
A valid credit card is required to book an appointment. The 50% deposit shall be paid within 24 hours of booking an appointment for the appointment to be considered confirmed. An invoice will be sent by email via Square for secure payment.

Cancellation Policy
I understand that unanticipated events happen occasionally in everyone's life. When you book an appointment that time is reserved especially for you. Missed appointments are costly in lost time and revenue, and it prevents me from providing services to other clients. In my desire to be effective and fair to all clients, the following policies are put in place:

24 hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give 24 hours advance notice you will be charged 50% of your scheduled appointment charge. This amount will be billed to you and must be paid prior to your next scheduled appointment.

No-shows
Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a no-show and will be charged for their missed appointment. The full amount for the session missed will be billed to you and must be paid prior to your next scheduled appointment.

*Gift certificates are marked as redeemed for no-shows or cancellation made less than 24 hour notice.
*No-shows or cancellation made less than 24 hours notice for packages will be deducted from the package.
*Gift certificates and packages are non-refundable.
*All sales, whether online, over the phone or in person are final.
*Prices are subject to change with or without notice.

Late Arrivals
If you arrive late to your scheduled appointment, your session may be shortened in order to accommodate others whose appointments follow yours. Your therapist will determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" scheduled session**.

Payment
Full payment is expected before or after treatment at the time of service. All clients, whether they have received treatment or booked an appointment are bound by this policy without any prejudice or exemption.

Returned Checks
There is a fee of $35.00 for a returned check.

By signing this I am stating that I fully understand and agree with the above policy.

Name: _____ Date:_____