Integrative Healing Arts

Medical and Wellness Massage

www.iha-holistic.us

Brenda Dickenson, LMBT

(NY# 28956 NC# 16935)

Oncology Massage Therapy Intake Form

Name: _____ Date of Birth: _____

Address: _____ City:_____

State:_____ Zip: _____ Phone (home/cell/work):_____

Pronoun: _____ (example: she/her, he/him, they/them) Email Address: _____

Occupation: _____ Referred by: _____

Emergency Contact: _____ Phone: _____

General and Medical Information:

Do you suffer from chronic pain? ☐ yes ☐ no If yes, please explain _____

_____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? ☐yes ☐ no If yes, please list:_____

_____

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

Explain any conditions you have marked above: _____

_____

_____

_____

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

_____

_____

_____

Please any known list allergies: _____

Have you ever had a professional massage? Yes No If so, was there anything you liked or didn't like?

_____

Are you sensitive to touch or pressure in any area? Yes No If so, where? _____

Reasons for seeking massage therapy: _____

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: _____

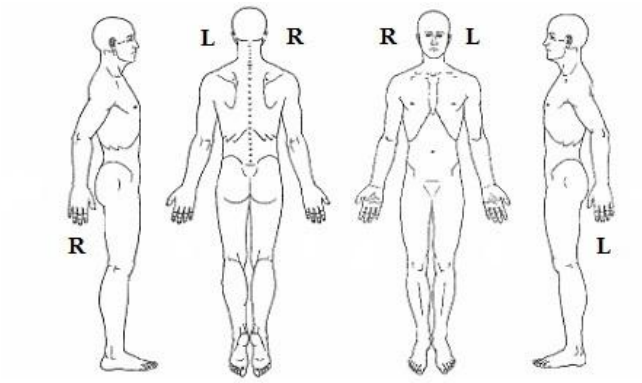
☐medical devices please describe:_____

☐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

Please identify the areas of concern on the chart below:



Release

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 answered all questions honestly, to the best of my knowledge 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 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 therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for 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 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 if I use a coupon during my visit, it is not valid with any other coupons or promotions. 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.

Print Name: _____

Signature: _____ Date: _____

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217 Union Street, Cary, NC 27511
(315) 415-3791

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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.

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 $25.00 for a returned check.

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

Name: _____ Date:_____