

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

Brenda Dickenson, LMBT
(NY# 28956 NC# 16935)

Oncology Massage Intake Form – rev 5/2021

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? _____

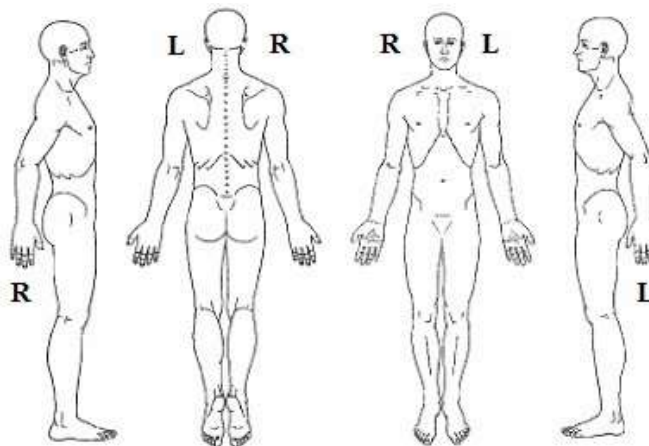
Any difficulty laying on your stomach or back? _____

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.

- | | | |
|--|--|--|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Anxiety / Depression |
| <input type="checkbox"/> Osteoporosis / Bone loss | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Back / neck problems | <input type="checkbox"/> Blood Clots / Clotting issues | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Broken Bone (in last 2 years) | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Circulatory disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Allergies / Sensitivity | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Current Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sprains or Strains | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Recent surgery (in last 2 years) | <input type="checkbox"/> Recent accident of injury | <input type="checkbox"/> Open Sores / Wounds |
| <input type="checkbox"/> Pregnancy - if so, how far along? _____ | | <input type="checkbox"/> 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
- bone or spine metastasis
- area of infection
- neuropathy
- radiation site
- fracture history
- history/risk of blood clot
- other (describe below)

Do you have any pressure restrictions due to:

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

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

Informed Consent

ACTIVITY DEFINED

- Massage therapy can be defined as structured, professional touch. Massage techniques manually manipulate the muscles, tendons, and fascia of the body to promote health and wellness.
- Massage therapist may employ, within the scope of practice and training, various parts of their body (hands, fingers, forearms, elbows, etc.) or other tools or implements, when providing your session.
- Topical preparations and/or heat and/or cold may be utilized during your appointment.
- Joint mobilizations, passive or active stretching, and other, similar techniques, may be employed.

LIMITATIONS

- Massage therapy is not a substitute for medical care. Massage therapists do not diagnose, prescribe, or treat any physical or mental illness. Massage therapists do not perform spinal or skeletal adjustments.

ADVERSE REACTIONS

- Massage may lead to adverse reactions in certain situations or when employed with certain conditions or medications.
- The massage therapist will evaluate your health questions and health history intake and ask you questions in an effort to determine that massage may be of benefit for you and safe for you to receive.
- Please provide complete details of medical conditions and medications to your massage therapist. Failure to inform the massage therapist of all medical conditions and medications may place you at increased risk for adverse reactions.
- In certain circumstances, your massage therapist may ask you to provide a note from your physician, or other medical professional, stating that it is safe for you to receive massage.

CONFIDENTIALITY

- Your personal health information will be kept confidential unless required by law or unless you provide specific, written consent for such information to be shared with another provider.

EXPECTATIONS

- You may be refused treatment if you arrive for an appointment and appear to be inebriated or under the influence of alcohol or drugs. Appointments that are not conducted for this reason may be charged in full and/or not refunded.
- Any behavior of a sexual nature is grounds for ending an appointment and/or refusal of future service. Appointments terminated for this reason will be charged in full and/or not refunded.
- You have the right to be treated respectfully, including the protection of your security and modesty while on the massage table. You may choose the level of undress you desire. Draping will be utilized for any level of undress.

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, LMBT (NY#28956 NC# 16935)

Print Name: _____

Signature: _____ Date: _____

Integrative Healing Arts
Brenda Dickenson, LMBT (NY# 28956 NC# 16935)
COVID-19 ADD 5/2021

CORONAVIRUS/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, LMBT (NY# 28956 NC# 16935) to proceed with providing care. _____
- I agree to wear a mask and/or suitable face covering from upon entering the office and that I will retain it, covering both my nose and mouth, throughout my appointment. I understand that my mask must be well fitting and clean or that I may be offered a disposable and sanitary mask to wear during my time in the office. _____
- I have been offered a copy of this consent form. _____

To give your consent, read and sign below:

I knowingly and willing consent to receive massage therapy care from Brenda Dickenson, LMBT (NY#28956 NC# 16935) 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, LMBT (NY# 28956 NC# 16935)
Cancellation/No-show policy rev 5/2021

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 \$30.00 for a returned check.

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

Name: _____ Date: _____