Sage CANCER CARE

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MASSAGE INTAKE FORM

Name: _____Gender: _____Date of Birth:_____

Address: _____

Preferred Contact Number: _____Alternate Number: _____

Emergency Contact Name/Contact Number: _____

Have you had Massage Therapy before? ☐ Yes ☐ No

If yes, was there anything you liked or didn't like? _____

_____

What kind of activities are you able to participate in? _____

Please give us a general idea of your current day-to-day or week-to-week activities, if any:

_____

CANCER HISTORY (if applicable)

Cancer type/location(s): _____ Date of diagnosis: _____ Active diagnosis? ☐ Yes ☐ No

Are you currently being treated? ☐ Yes ☐ No If no, what was the date of your last treatment? _____

NOTE: If you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of the massage session, please have your physician complete the MD permission form.

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

_____

_____

Current medications (for cancer or other conditions) not described above:

_____

_____

Did your treatment include any 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: _____

Do you have any ***site restrictions*** due to:

- ☐ Incisions, open wounds, drains, or dressings
- ☐ Skin sensitivity, rash, or other skin condition
- ☐ IV, port, ostomy, catheter, or other device
- ☐ A tumor site
- ☐ Radiation site
- ☐ Bone or spine metastasis
- ☐ Fracture history
- ☐ Area of infection
- ☐ History/risk of blood clot
- ☐ Neuropathy
- ☐ Other (please describe): _____

Do you have any ***pressure restrictions*** due to:

- ☐ History/risk of lymphedema (*circle one*)
- ☐ Anticoagulants
- ☐ Low platelet count
- ☐ Bone or spine metastasis
- ☐ Steroid medications
- ☐ Infection or fever
- ☐ Fragile/sensitive skin
- ☐ Fragile veins
- ☐ Area of pain or burning
- ☐ Fatigue
- ☐ Recent surgery
- ☐ Other (please describe): _____

Do you have any ***position restrictions*** due to:

- ☐ Incision
- ☐ Medication
- ☐ Ostomy
- ☐ Tender skin
- ☐ Tumor site
- ☐ Difficulty breathing
- ☐ Swelling or risk of swelling (***Please describe***: _____)
- ☐ Medical devices (***Please describe***: _____)
- ☐ Discomfort (***Please describe***: _____)

Has cancer or cancer treatment affected any of the following functions in your body?

- ☐ Lungs (***Please describe***: _____)
- ☐ Liver (***Please describe***: _____)
- ☐ Nervous system (***Please describe***: _____)
- ☐ Heart (***Please describe***: _____)
- ☐ Kidney (***Please describe***: _____)
- ☐ Blood counts (***Please describe***: _____)
- ☐ Energy level (***Please describe***: _____)

GENERAL SIGNS AND SYMPTOMS

Check "yes" and add comments if you have or have had any of the following:	***Yes***	***No***	***Comments***
Any swelling or tendency to swell anywhere in 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 of inflammation?	☐	☐	

OTHER MEDICAL CONDITIONS

Check "yes" and add comments if you have or have had any of the following:	***Yes***	***No***	***Comments***
Skin conditions (rashes, infections, itching)	☐	☐	
Known allergies or sensitivities (if you use any well-tolerated lotion on your skin, please bring it for us to use with you)	☐	☐	
Cardiovascular conditions (ex: heart disease, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)	☐	☐	
Liver of Kidney conditions (ex: kidney failure, hepatitis, portal hypertension)	☐	☐	
Respiratory or Lung conditions	☐	☐	
Diabetes (describe type, any medication, whether blood sugar is well-controlled)	☐	☐	
Injuries (any back, neck, hip, or knee problems, tendonitis, disc injuries, fractures)	☐	☐	
Arthritis or Joint problems	☐	☐	
Digestive problems	☐	☐	
Surgery	☐	☐	

MASSAGE THERAPY CONSENT TO TREAT

This record of consent is required before the first assessment or treatment and will be maintained confidentially in the client file. It may only be released to a third party with prior written consent of the client.

Massage Therapy includes the assessment and treatment of the soft tissues and joints of the body, using soft tissue manipulation, joint mobilization, hydrotherapy, remedial exercises and self-care programs as determined by the therapist. Treatment plans will be discussed in advance with the client and must be agreed upon prior to start.

By signing below, the client agrees to the following:

- All massage treatments, information, and records will be kept confidential and securely stored for use only by my massage therapist.
- Written consent must be given by me prior to any disclosure or sharing of my personal and clinical information with any third party.
- Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of the treatment.
- Draping will be used by the therapist as required to expose only those parts of my body that require treatment and/or as I choose to ensure my comfort during treatment.
- During treatment, the therapist will endeavor to work such that a pain level of 6-7 is not exceeded, based on a pain scale of 1 to 10.
- If at any time during the treatment, I feel uncomfortable with the treatment for any reason, I have the right to request an immediate stop to the session or request modifications to the treatment, regardless of prior consent given.
- Promptness is expected for all appointments. In the event of lateness, the massage may be cut short due to other commitments of the therapist. Fees will be maintained per the schedule.
- Cancellation of any appointment must be received at least 24 hours in advance; otherwise, 50% of the appointment fee is due.
- Fees for treatment are due prior to departure on the day of the treatment. Cash or personal checks are accepted.
- The therapist may refuse to treat any client or part of their body with just and reasonable cause.

I, _____ (PRINT NAME), have read and understood the information above and consent to the massage treatment for the condition discussed with my therapist today.

Client Signature: _____ Date: _____

Therapist: _____