

Keldara Caring Hands Massage Intake Form - CONFIDENTIAL INFORMATION

Your answers to the questions on this form are essential for a safe, effective massage therapy session. Please take some time to answer in detail.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ___/___/___ Home #: _____ Work#: _____

1. Have you had massage therapy before? Yes No If yes, what did you like or dislike about your previous massage?

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

3. Where was/is it located? _____

4. Are you being treated now? **Yes No** If no, what was the date of your last treatment? _____

NOTE: If you are currently in treatment, or if your last treatment session was less than 12 mos. ago, please have your physician complete the Physician's Permission Form.

Dr. Name: _____ Dr. Contact#: _____ May we contact? No Yes

5. What treatments have you undergone? Please supply detail, with dates and types of cancer treatments.

6. Current medications, not described above: _____

7. Did your treatment include any removal or radiation of lymph nodes? **(if yes, please describe where)**

8. Did your treatment include radiation therapy? **(If yes, please describe areas of your body affected)**

9. 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 ___ neuropathy
- ___ fracture history ___ area of infection
- ___ history or risk of blood clots or phlebitis
- ___ other **(please describe)**

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

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

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

- ___ incision ___ medication ___ ostomy ___ difficulty breathing ___ tender skin
- ___ swelling or risk of swelling (any body area need elevating?) **please describe** _____
- ___ medical devices **please describe** _____
- ___ discomfort **please describe** _____

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

- ___ Lungs ___ Liver ___ Nervous System ___ Heart ___ Kidney
- ___ Blood counts ___ Energy Level

(circle any that you are currently experiencing and describe _____)

General Signs and Symptoms

Check "yes" or "no" and add comments 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 of 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" or "no" and add comments if you have Or have had any of the following:	Yes	No	Comments
17. Skin conditions (rashes, infections, itching)			
18. Known allergies or sensitivity (if you use any physician-approved lotion on your skin please bring it for the massage therapist to use)			
19. Cardiovascular conditions (for example: heart condition, high blood pressure, angina, hardening of the arteries, history of stroke, severe varicose veins, blood clots)			
20. Liver or Kidney conditions (for example: 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 problems, knee problems, tendonitis, disc injuries, neck problems, recent fractures)			
24. Arthritis or joint problems			
25. Gastrointestinal problems			
26. Surgery			

We reserve the right to refrain from providing a massage service until written permission is given by your medical professional.

Important note: It is my choice to receive massage therapy. I understand that the information given above is strictly confidential and will be used for no other purpose than to assist the massage therapist in providing a suitable massage which would take into consideration my specific requirements. I also understand that failure to disclose all my known medical conditions could result in injury and or illness. I hereby release Keldara Salon and Day Spa from any claims resulting in such. Any information provided to me by the massage therapist is for general educational purposes only and is not intended for any medical or therapeutic purpose.

Client Signature: _____

Date _____ / _____ / _____

Thank you for choosing Keldara Salon and Spa!