G-MEDICAL MASSAGE SPA

Oncology Client Information

Name_____ Phone (____)_____ DOB_____

Addres _____ City _____ State _____ Zip _____

E-mail _____

In case of emergency _____

ICE Phone _____ ICE Relationship: _____

Found Us How?: ☐ Yelp ☐ Google or Referred By: _____

Occupation: _____

Preferred contact method for Appointments? Please check box. ☐ Call ☐ Text ☐ Email

Would you like to be on our mailing list for discounted promotions? ☐ Yes ☐ No

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Please take a moment to carefully read the following information and sign the waiver where indicated.
A referral from your primary care provider may be required prior to service. Please make sure your doctor is aware you are recieving this treatment.

Have you ever experienced a professional massage? ☐ Yes ☐ No How recently? _____

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1. Have you had Massage Therapy before? Yes ____ No ____ If yes, was there anything that you liked or didn't like? _____

2. What kind of activities/exercise do you do? _____

3. When were you first diagnosed with cancer? _____ What type of cancer? _____
   Where was/is it located? _____

4. Are you be ing treated now? Yes ____ No ____
   If no, what was the date of your last treatment? ____/____/_____ (If you are currently in treatment, or, if your last treatment session was less than 12 months ago, please have your physician complete the accompanying *permission* form.)

5. What treatments have you undergone? Please supply details and types of cancer treatments.
   _____

6. Did your treatment include any removal or radiation of lymph nodes? Yes____ No_____
   If yes, please describe where: _____

7. Did your treatment include radiation therapy? Yes_____ No_____
   If yes, please describe the areas of your body that were affected. _____
   _____ _____

8. Do you have any position restrictions? Yes_____ No_____
   If yes, please describe where: _____

9. Do you have any site restrictions due to:

- ☐ incisions, open wound, drains or dressings
- ☐ skin sensitivity, rash or skin condition
- ☐ bone/spine metastasis
- ☐ history/risk of blood clots or phlebitis
- ☐ infected area
- ☐ IV, port, ostomy, catheter
- ☐ a tumor site
- ☐ radiation site
- ☐ neuropathy
- ☐ fracture history

___other: _____

10. Do you have any pressure restrictions due to:

- ☐ history of lymphedema
- ☐ anticoagulanats
- ☐ bone/spine metastastis
- ☐ area of pain/burning
- ☐ fatigue
- ☐ steroid meds
- ☐ fragile veins
- ☐ recent surgery
- ☐ low platelet count
- ☐ fragile/sensitive skin
- ☐ fever/infection

___other: _____

General Signs and Symptoms:	YES	NO	Comments
13. Any swelling or tendency to swell anywhere in your body?	○	○	
14. Any sites of pain/tenderness anywhere in your body?	○	○	
15. Any sites of numbness or reduced sensation in your body?	○	○	
16. Any areas of inflammation?	○	○	
Other Medical conditions:	**YES**	**NO**	**Comments**
17. Skin conditions (rash/itching)	○	○	
18. Allergies or sensitivities	○	○	
19. Cardiovascular concerns (such as blood clots, etc)	○	○	
20. Liver/kidney conditions	○	○	
21. Respiratory or lung conditions	○	○	
22. Diabetes	○	○	
23. Injuries	○	○	
24. Arthritis or joint problems	○	○	
25. Gastronintestinal problems	○	○	
26. Surgery	○	○	

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners 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 session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ **Date** _____

Practitioner Signature _____ **Date** _____