Sacred Grove Healing Massage David Peter Armentano LMT, MTI, CE Provider
License Number: MT111247, MI3170, CE1858 (469)-309-8243

Oncology Massage Intake Form

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone/Cell: _____

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? _____
    a. What type of cancer? _____
    b. Where was it located? _____
4) Are you being treated now? Yes _____ No ____
    a. If no, when was your last treatment? _____/_____/_____ (If you are currently in treatment or, if your last treatment was less than twelve (12) months ago please have your physician give a referral note that authorizes treatment.)
5) What treatments have you undergone? Please supply details of types of cancer treatments.

_____

Current cancer medications not described above: _____

6) Current medications for any other condition: _____
    _____
7) Did your treatment include the removal or radiation of lymph nodes? Yes ____ No ____
    a. If yes, please describe where? _____
8) Did your treatment include radiation therapy? Yes ____ No ____
    a. If yes, please describe the areas of your body that were affected. _____

_____

9) Do you have any position restrictions? Yes ____ No ____
    a. If yes, please describe where: _____
10) Has cancer/cancer treatment affected any of the following functions in your body?
    a. Heart ____
    b. Kidney ____
    c. Blood Counts: White Count ____ Red Count ____ Platelet ____
    d. Energy levels ____
11) Do you have any site restrictions due to any of the following (Check all that apply):

____ Incisions, open wounds, drains or dressings	____ IV port, ostomy, catheter
____ Skin sensitivity, rash or skin condition	____ A tumor site
____ Bone/Spine metastasis	____ Radiation Site
____ History/risk of blood clots or phlebitis	____ Neuropathy
____ Infected area	____ Fracture History
____ Other: _____	

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12) Do you have any pressure restrictions due to any of the following (Check all that apply):

____ History of Lymphedema ____ Fatigue ____ Low Platelet Count
____ Anti-coagulants ____ Steroid Meds ____ Fragile/sensitive skin
____ Bone Spine Metastasis ____ Fragile veins ____ Fever/Infection
____ Area of pain/burning ____ Recent Surgery
____ Other: _____

General Signs and Symptoms	Yes	No	Comments
Any swelling or tendency to swell anywhere in your body?			
Any sites of pain/tenderness anywhere in your body?			
Any sites of numbness or reduced sensation in your body?			
Any areas of inflammation?			
Other Medical conditions:	**Yes**	**No**	**Comments**
Skin Conditions (rash/Itching)			
Allergies or sensitivities			
Cardiovascular concerns (Such as blood clots, etc.)			
Liver/Kidney Conditions			
Respiratory or Lung Conditions			
Diabetes			
Injuries			
Arthritis or Joint problems			
Gastrointestinal problems			
Surgery			

I understand it is my choice to receive massage therapy and that the treatment being given is for the purpose of stress reduction, relief from muscle tension, spasm and/or pain, or for improving circulation. I understand that massage is not a replacement for medical treatment and that my therapist cannot offer diagnosis or treatment, other than massage for any medical conditions I may or may not have as authorized by my treating physician. I also hold no liability to the therapist for any side effects from the massage (nausea, dizziness, vomiting, metastasis of cancer, however unlikely).

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____