Client Health History Form

Name _____ Date _____

Street Address_____ City, State Zip _____

Telephone # _____ Alternate Telephone # _____

Date of Birth _____ Emergency Contact Name/Telephone_____

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

   _____

2. 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.

   _____

3. When were you first diagnosed with cancer? _____

   What type of cancer? _____

   Is cancer currently active? _____

   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, 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.

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

6. Current ***medications*** (for cancer or other condition) 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 where)*** _____

   _____

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
_____neuropathy
_____bone or spine metastasis
_____fracture history
_____area of infection
_____history/risk of blood clot
_____other ***(please describe below)***

_____

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

_____history or risk of lymphedema ***(circle which)***
_____anticoagulants
_____low platelet count
_____bone or spine metastasis
_____steroid med
_____fragile/sensitive skin
_____fragile veins
_____area of pain or burning
_____fatigue
_____recent surgery
_____infection or fever
_____other ***(please describe below)***

_____

11. 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 _____

12. Has cancer or cancer treatment affected any of the following functions in your body? ***(circle current issues)***

_____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***
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" and comments if you have or have had any of the following:	***Yes***	***No***	***Comments***
17. ***Skin conditions*** *(rashes, infections, itching)*			
18. Known ***allergies*** or ***sensitivities*** *(if you use any physician-approved or well-tolerated lotion on your skin, please bring it for us to use with you)*			
19. ***Cardiovascular conditions*** *(History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, 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, neck, hip or knee problems, tendonitis, disc injuries, recent fractures)*			
24. ***Arthritis or Joint problems***			
25. ***Digestive problems***			
26. ***Surgery***			