

**Shine Therapy Massage Intake Form**

**Today's Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_

Your address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Oncologist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For FUNDING purposes:**

Persons in household: \_\_\_\_\_\_\_ Annual Income: \_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_ Health Insurance: YES / NO

Does your insurance cover most of your cancer related expenses? Yes / no

**Oncology Medical History:** Exact cancer diagnosis, including any metastasis (spread) of cancer/location:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in Treatment? Yes / no

**Surgery:**  Please provide (dates) and type of surgery(s), and results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lymph node damage (surgery, radiation, etc)** YES / NO

**Location of node damage:** arm - left/right, leg - left/right, neck , face, trunk

**Do you have any** swelling, pain, heaviness, or heat **in that area?**  Have you been treated for lymphedema? yes / no

**Chemotherapy:** Please provide the start dates and end dates of chemotherapy. Please provide the schedule if in active treatment and the name of the drugs being administered: Do you have a portacath? yes / no Where?\_\_\_\_\_\_\_\_\_\_\_\_

Drug(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Start(s)\_\_\_\_\_\_\_\_\_\_\_\_\_End(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Schedule(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Start(s)\_\_\_\_\_\_\_\_\_\_\_\_\_End(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Schedule(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide chemo side effects if any: Joints swelling rash other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Radiation:** If you have had radiation, please provide the start and end dates. Please provide the schedule if in active treatment.

Radiation Area:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Start\_\_\_\_\_\_\_\_\_\_\_End\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Schedule\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any skin reactions or burns, blisters*,* orrash due to radiation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Blood Work:** Please provide current information on blood counts. Are you taking Neupogen, Procrit, warfarin, or other medications to build or alter your blood counts: YES/NO

Hemoglobin \_\_\_\_\_\_\_ Platelets\_\_\_\_\_\_\_\_\_\_ White blood cells \_\_\_\_\_\_\_\_\_\_ DO YOU HAVE A BLOOD CLOT? YES/NO

**Additional medical history:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of condition** | Receiving Care? | Type of Condition | Receiving Care? |
| \_\_\_Diabetes | Yes / No | \_\_\_Osteoarthritis | Yes / No |
| \_\_\_Hypertension | Yes/ No | \_\_\_Pregnancy | Yes / No |
| \_\_\_Heart Disease | Yes/ No | \_\_\_Epilepsy | Yes / No |
| \_\_\_Asthma | Yes/ No | \_\_\_Bleeding Disorder | Yes / No |
| \_\_\_Depression | Yes /No | \_\_\_Skin Infections/rash | Yes / No |
| \_\_\_Varicose Veins | Yes/ No | \_\_\_Neuropathy | Yes / No |
| \_\_\_Open wounds | Yes/ No | Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |

If you have any additional physical accidents, trauma, or surgeries, please list them here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies: A**llergies to lotion ingredients, including nut oils? yes / no Latex? Yes / no Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** Please list all types of doctor prescribed medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain rating:**

**Physical:** On a scale of 0-10 with 0 being NO pain and 10 being the WORST pain, please rate the pain you are having TODAY and the location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emotional:** On a scale of 0-10 with 0 being NO distress and 10 being the WORST stress possible, please rate the stress/anxiety level you are having TODAY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclosure:** I understand that massage therapy is given here for the purposes of stress reduction, relief from muscular tension or spasm, or for increasing circulation or energy flow. I understand that the massage therapist does not diagnose illness or disease and, therefore, does not prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. Massage therapy is not for sexual gratification. The therapist will maintain appropriate draping at all times. Therapist will not engage in breast massage of female clients. If at any time I am uncomfortable with the massage, I should ask the therapist to stop, change techniques, or end the massage. I have stated all my known medical conditions and acknowledge my responsibility to inform the therapist of any changes. The therapist has **the right to refuse** providing a massage based on your identified health issues at the time you present for an oncology massage. Your safety is important.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of parent or legal guardian giving permission for Shine Therapy to provide massage to client if client is a minor child. Child’s age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or legal guardian print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or legal guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_