ONCOLOGYMASSAGE TRAINING

Client Medical History Form

Health Fund:

Name: _____ **DOB:** _____

Address: _____ **P/C:** _____

Home: _____ **Work:** _____ **Mobile:** _____

Occupation: _____

GP: _____ **Phone:** _____

Address: _____

Type of cancer and location: _____

Date of diagnosis: _____

Rx received and to what areas of the body?

Y ☐ N ☐ **Surgery:** _____

Y ☐ N ☐ **Chemotherapy:** _____

Y ☐ N ☐ **Radiotherapy:** _____

Are you receiving Rx other than Medical as described above?

If yes, what type of treatment? _____

If no, when did you finish your treatment/s? _____

Pressure Related Considerations

Y ☐ N ☐ Fatigue _____

Y ☐ N ☐ Easy bruising (low platelets) _____

Y ☐ N ☐ Neutropenia (low white count _____

Y ☐ N ☐ Neuropathy in the hands and/or feet _____

Y ☐ N ☐ Lymph node removal in the Axilla, Neck or Groin _____

Y ☐ N ☐ Oedema or Lymphoedema _____

Y ☐ N ☐ Bone density loss _____

Y ☐ N ☐ Central line in situ _____

Y ☐ N ☐ Other _____

_____

_____

_____

Site Related Considerations

- ☐ Pain or Discomfort
- ☐ Incisions
- ☐ Area that feels unusually warm
- ☐ Skin Problems
- ☐ Other medical devices
- ☐ Tumour
- ☐ Recent Hx of Blood Clots
- ☐ Other

_____

_____

_____

_____

Other Significant Medical History (Surgeries, Diabetes, Blood Pressure, Viral Infections etc)

_____

_____

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_____

_____

_____

Positioning Adjustments:

_____

_____

I understand that:

there is a possibility of slight bruising, depending on the type of therapeutic massage undertaken. There may be one – two days of musculature discomfort after the therapeutic massage/~~reflexology/reiki treatment~~ as the muscles adjust to their new status. Please drink at least two litres of water per day for optimal health and to also flush the toxins from the body that are released during the therapeutic massage/~~reflexology/reiki~~ treatment. If the toxins are not released through elimination then headaches and nausea may be present for several days.

Confidentiality is respected and at no time is any information received from the client during the therapeutic massage/~~reflexology/reiki~~ session given to any other person, except with express permission from the client.

Therapeutic treatments are given with all due care and practiced with professionalism in a responsible manner by Barbara

Signature: _____ Date: _____

(Print name): _____

I understand that the massage therapy I receive is for the purpose of relief from muscular tension, spasm or pain and stress reduction. If I experience any pain or discomfort during this session, I will immediately tell Barbara so that the pressure and/or strokes may be adjusted to my level of comfort.

I understand that Barbara does not diagnose illness or disease or perform any spinal manipulations, nor does she prescribe any medical treatments, and nothing said or done during the session should be construed as such.

I further acknowledge that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

I agree to keep Barbara updated as to any changes in my medical profile and understand that there shall be no liability on her part should I fail to do so.

_____ _____

Signature **Date**

Please mark your areas of pain / stiffness: