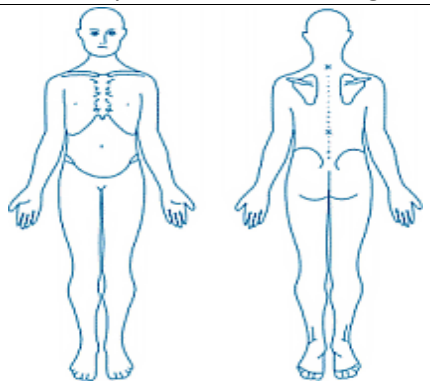
Client Health Form for Massage Therapy		**Progressive Massage Therapy Susan Gee, LMT**
Name:		Best phone:
Address:		Email:
City, ST, Zip:		Date of birth: / /
Emergency contact & phone:		Occupation:
How did you hear about us?		May I send mail to these addresses? Yes/No

Massage Therapy		
Have you had Massage Therapy before?	Yes/No	Please circle areas you would like massage to address.
If yes, what did you like most?		
If yes, what did you like least?		
On a scale of 0-10, describe your stress level:		
On a scale of 0-10, describe your pain level:		
(O=no pain/10=worst pain imaginable)		
Please elaborate below:		

Health Issues		
When were you first diagnosed with cancer?		Specific type of cancer?
Where was/is it located?		What stage of cancer?
Are you being treated now?	Yes/No	If no, date of last treatment:

What treatments have you undergone, when? Please provide dates/types of surgery and other treatments.

Date	Type

Current medications not described above:

Did your treatment include radiation therapy? If yes, where? How many treatments?

Did your treatment include any removal or radiation of lymph nodes? Yes/No

If yes, please describe where:

Site Restrictions - Areas to avoid during massage.

Do you have any site restrictions due to any of the following? (Please circle if yes.)

Incisions	Rash	IV, port, ostomy, catheter or other device
Open wounds	Skin condition	Fracture history
Drains or dressings	A tumor site	History or risk of blood clots or phlebitis
Neuropathy	Bone or spine metastasis	Raditation site
Area of infection	Other:	

Pressure Restrictions - The amount of pressure used during massage.

Do you have any pressure restrictions due to any of the following? (Please circle if yes.)

History or risk of lymphedema	Steroid medication	Area of pain or burning
Anticoagulants	Fragile/sensitive skin	Infection or fever
Low platelet count	Fragile veins	
	Other:	

Position Restricitons - Do you have trouble laying on your stomach, back, etc?		
Do you have any position restriction due to:		
Incisions	Medications	Ostomy
Tumor site	Difficulty breathing	Tender skin
Swelling or risk of swelling	Medical devices	Elevation of any body part? If yes,
Discomfort		please explain:
Body Functions		
Has cancer or cancer treatment affected any of the following functions in your body?		
Please circle any that you are experiencing and describe:		
Lungs	Nervous system	Kidney
Liver	Heart	Blood counts

Physical Conditions			
Allergies to lotions/oils	Yes/No	Liver or Kidney	Yes/No
Arthritis or joint	Yes/No	Mouth sores/Dry mouth	Yes/No
Breathing	Yes/No	Nausea	Yes/No
Cardiovascular conditions	Yes/No	Pain or tenderness	Yes/No
Concentration	Yes/No	Respiratory or Lung	Yes/No
Constipation	Yes/No	Skin rashes	Yes/No
Cough	Yes/No	Sleep	Yes/No
Depressions	Yes/No	Swallowing	Yes/No
Diabetes	Yes/No	Sweats	Yes/No
Diarreha	Yes/No	Swelling	Yes/No
Digestive problems	Yes/No	Vomiting	Yes/No
Dizziness	Yes/No	Weight loss	Yes/No
Eating/change in the way food tastes	Yes/No	Others? Please list below:	
Fatigue/Lack of energy	Yes/No		Yes/No
Feeling bloated	Yes/No		Yes/No
Feeling swollen	Yes/No		Yes/No
Hair Loss	Yes/No		Yes/No
Inflammation within the body	Yes/No		Yes/No
Injuries: back, neck, knee, recent fractures	Yes/No		Yes/No

Informed Consent:

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I understand this does not deter me from seeking medical treatment. I understand that no inappropriate comments or conduct will be tolerated. Any indication of such behavior will end the session. I agree to update the therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so. I agree to hold harmless the establishment and all personnel, from and against any and all claims. I agree to handle suit at its sole expense and agree to bear all costs related even if claims, etc. are groundless, false and fraudulent.

I agree to give the therapist a 24-hour notice if I must cancel an appt. and understand that same-day cancellations will be charged full-fee. **Revised 11.13**

Client Signature:	Date:
Therapist Signature:	Date: