Blissful Beginnings & Beyond
Client Information Form for
Clients with Cancer Treatment History

Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone# (Home)_____ **(Cell)**_____ **Email** _____

Preferred Method of Contact: ____Home Phone ____ Email ____Cellphone Do you want to receive text messages for appointment reminders and discount specials? ___ No ___Yes (if yes, provide cellphone carrier co)_____
Occupation_____ **Employer**_____

Emergency Contact _____ **Phone #** _____ **Relationship** _____

Medications_____ **Physician**_____

Age_____ **Birth Date**_____ **Referred By**_____

Primary reason for appointment:_____

Areas of complaint, pain or tension:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE APPROPRIATE ANSWER:

YES NO Have you had a professional massage before?
YES NO Have you ever had surgery?
If YES, please describe_____
YES NO Do you wear contact lenses or dentures?
YES NO Do you have any skin problems or allergies?
YES NO Do you take any prescribed medication?
If YES, please describe_____
YES NO Have you had any broken bones or acute injury in the past 2 years?
If YES, please describe_____
YES NO Do you have arthritis or osteoporosis?
YES NO Are you epileptic or seizures?
YES NO Are you diabetic?
YES NO Do you have varicose veins, phlebitis or blood clots?
YES NO Do you have cardiac or circulatory problems?
YES NO Do you exercise regularly or participate in any sports?
If YES, what kind and how often_____
YES NO Do you have any spinal problems?
If YES, what is diagnosis_____
YES NO Are you pregnant?
YES NO Do you have high blood pressure?
YES NO Do you have tension or soreness in a specific area?
If Yes, please describe_____
YES NO Do you have any other medical condition I should be aware of?
If Yes, please describe_____

Had you ever received bodywork before your cancer diagnosis ? _____ If so, what types?

_____

Have you received bodywork since your cancer diagnosis? _____ If so, when and what types?

_____

Do you see a chiropractor? If so, how often?_____

Why have you come for massage today?

_____

Is there anything specific that you hope to achieve through massage?

_____

When were you diagnosed with cancer? _____ What type of cancer? _____

Where is/was it located? _____

Are you being treated now? Yes No If no, what was the last date of your treatment?

_____

What **treatments** have you undergone or are you currently undergoing? *Please supply dates and types of treatments to the best of your ability.*

_____

_____

_____

Please list any **medications** you are currently taking, in addition to any chemotherapy drugs listed above, and any **side effects** you experience.

Medication **Side Effect**

Did your treatments include any **removal or irradiation of lymph nodes**? *(if yes, please describe)*

To your knowledge, do you have any **site restrictions** due to :

____*incisions, open wounds, dressings*

____*skin condition, rash or sensitivity*

____*medical devices such as IV or ostomy*

____*tumor site* ___ *radiation site(s)*

____*a history of blood clots or phlebitis*

____*bone or spinal metastases* ____*neuropathy*

____*history of fractures* ____*bone fragility*

____*area of infection* _____*other (please describe)* _____

To your knowledge, do you have any **pressure restrictions** due to:

____*history of risk of lymphedema*

____*anticoagulants* ____*low platelet count* ____*bone metastases*

____*steroid medication* ____*fragile/sensitive skin* ____*fragile veins*

____*area(s) of pain or burning* ____*fatigue* ____*recent surgery*

____*infection or fever* ____*other (please describe)* _____

Do you have any **position restrictions** due to:

____incision ____medicaiton ____ostomy ____tumor site ____difficulty breathing ____tender skin ____swelling or risk of swelling *(any area of the body require elevating?) please describe* _____

medical devices _____

discomfort _____

Has cancer or cancer treatment affected any of the following functions in your body?

___lungs ____liver ____nervous system ____heart ____kidney ____blood counts ____energy level

If yes, please describe _____

_____

General Signs and Symptoms

Check "yes" & add further comments if you have had any of the following sign/symptoms	**Yes**	**No**	**Comments**
Swelling or tendency to swell anywhere in your body			
Sites of pain/tenderness			
Sites of numbness/diminished sensation			
Inflammation			

Specific Medical Conditions

Check "yes" & add further comments if you have had any of the following sign/symptoms	**Yes**	**No**	**Comments**
Skin conditions (rashes, infections, allergies, itching)			
Known **allergies/sensitivities** (Do you use any non-allergenic or physician-approved lotion?)			
Cardiovascular conditions (e.g. heart condition, angina, high blood pressure, ateriosclerosis, phlebitis, thrombosis, etc)			
Liver or **kidney** conditions			
Respiratory or **lung conditions**			
Diabetes			
Arthritis			
Injuries (e.g. disc problems, tendonitis, knee problems, fractures, etc)			
Surgery			
Any conditions NOT MENTIONED			

How would you rate your **diet**? Very Healthy _____ Somewhat Healthy _____

Not Very Healthy _____ Needs Improvement _____

How much uninterrupted **sleep** do you get each day, on average? _____ none _____1-3 hours ____ 4-5 hours ____ 6-7 hours ___ 8+ hours

If you are having trouble sleeping, what is the primary reason? ____ anxiety ____pain ____outside interruption (family, noise, etc) ____other *(please explain)*_____

On average, how much **water** do you drink each day? (as a reference, a soft drink can contains 12 oz.) Less than one 8oz. Glass _____

More than five 8oz. Glasses _____ Eight or more 8oz. glasses _____

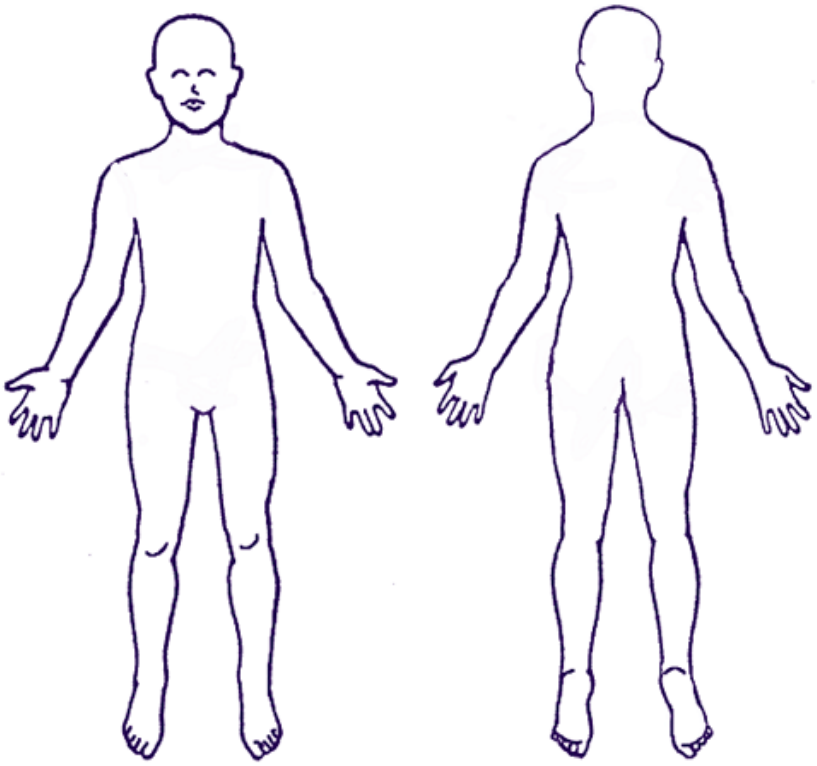
Are you **able to relax**? Yes No If so, What do you usually do to relax?

_____

Is there **anything else** that you think I should know? _____

_____

Please indicate any areas of discomfort or pain on the diagrams below. Rate your discomfort in each area using a scale of 1-10. 1= very mild ; 10= extreme, intrusive pain



Feel free to make notes next to any areas of pain that you feel require explanation.

Thank you!

Please take a moment to carefully read the following information and sign where indicated.
If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature_____ Date_____

Practitioner Signature_____ Date_____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian:_____ Date:_____