Aches Away tm
massage specialists

CLIENT INFORMATION - ONCOLOGY MASSAGE RELEASE FORM

Personal Information

Name: _____ Date: _____ Date of Birth: _____
Address: _____ City: _____ State ____ Zip _____
Phone: _____ Occupation: _____ Email: _____
Emergency Contact Name and Phone: _____
Oncologist Name and Phone: _____
How did you hear about us? *(Online search, gift certificate, social media, name of referrer - so we can thank them, other?)*
_____

Health Information

When were you first diagnosed with cancer? _____ What type of cancer?_____
Is your cancer currently active? Yes / No Where is/was it located? _____
Have you received radiation or chemo (circle one) treatment? Yes / No If yes, when was your last treatment? _____
Are you currently in treatment? Yes / No If No, what was the date of your last treatment? _____
Did your treatment include the removal or radiation of lymph nodes? Yes / No
Do you currently have any pain/numbness/changes in sensation? Yes / No
If yes, please describe:
_____
List current medications (for cancer or other conditions). Attach separate sheet, if needed: _____
_____
Has cancer or cancer treatment affected any of the following **functions/areas** of your body?
___Lungs ___Heart ___Liver ___Bone ___Circulatory(Blood) ___Hair/Scalp
___Nervous System ___Kidney ___Skin ___Taste ___Stomach/GI/Digestion

Restrictions

1. Do you have any **site restrictions for massage** due to: (Check any that apply)
Please check any cancer related contraindications that you have been or are currently being treated for:

___Incisions, open wounds, drains, or dressings
___Skin sensitivity, rash, or skin conditions
___IV If yes, where:_____
___Port If yes, where:_____
___Ostomy If yes, where:_____
___Catheter
___Tumor site If yes, where:_____
___Radiation Site If yes, where:_____
___Neuropathy If yes, where:_____
___Bone or spine mets If yes, where:_____
___Fracture history If yes, where:_____
___Area of infection If yes, where:_____
___History/risk of blood clot
___Other (Please describe) _____
_____

2. Do you have any **pressure restrictions for massage** due to: (Check any that apply)

___History or risk of lymphedema
___Anti-coagulants
___Low platelet count
___Bone or spine metastasis
___Steroid medication
___Fragile/sensitive skin
___Fragile veins
___Area of pain or burning
___Fatigue
___Recent surgery
___Infection or fever
___Other (please describe) _____
_____

3. Do you have any **position restrictions for massage** due to: (Check any that apply)

___Incision
___Medication
___Swelling or risk of swelling
___Tender skin
___Ostomy
___Tumor site
___Medical devices If yes, where:_____
___Difficulty breathing
___Discomfort If yes, where:_____

Please check any other conditions that you have been or currently being treated for:

___Allergy to Latex
___Uncontrolled blood pressure
___Heart Disease
___Allergic to Perfumes
___Controlled High Blood Pressure
___Sinusitis

(continue to pg.2)

___Dizziness/Vertigo
___TMJ Dysfunction
___Arthritis
___Bunions
___Chronic Muscle Pain
___Acute Muscle Pain/Spasm
___Spinal Subluxation (chiropractic)
___Other (please specify) _____

___Tinnitus (ringing in the ears)
___Migraines
___Tendonitis
___Neurological Disorder (specify)
___Fibromyalgia
___Anatomically Short Leg
___Fused Vertebrae (specify)

Please describe anything you would like to address in the session today, and/or any areas of concern:
_____
_____
_____
_____

List any musculoskeletal surgeries and severe injuries you have had: _____

List any other surgeries and severe injuries you have had: _____

Why are you here for a massage today?
___Just to relax
___Referral from a friend
___Injury Prevention (increase range of motion, joint mobility)
___Chronic or Acute Pain/Spasms
___Doctor or Chiropractic Referral
___Other? _____

What areas of your body need specific attention? _____

What did you like or dislike about previous massages? _____

Are you comfortable letting your therapist know if you have concerns about pressure, temperature, or anything else during your session? Yes / No

**********Please take a moment to carefully read the following information and sign where indicated**********

Oncology Massage Information and Informed Consent

When receiving an Oncology Massage, it is important to consult with your medical team before receiving bodywork. Oncology massage is a specialized and therapeutic massage session, tailored for the person in cancer treatment or recovery. Unlike many other massage modalities, oncology massage is not a series of techniques or applied protocols. Rather, it is the therapist's ability to identify and work within a framework of clinical considerations in order to make the bodywork adjustments that may be required as a result of any positioning, pressure or site considerations, i.e., medical devices, treatment related side effects from medication, chemotherapy, radiation or surgery, and the required massage stroke direction modifications if lymph nodes were compromised during treatment. If you are currently having or developing complications, please contact your medical provider as soon as possible.

Please read and sign the acknowledgement.

I understand that it is my responsibility to consult my physician regarding questions included on this Oncology Massage Release Form, and any other considerations pertaining to my current medical status that may affect delivery of this service. I understand that I will be receiving massage therapy for the purpose of stress reduction, relief from muscle tension or spasm, and/or for an increase in circulation and energy flow. I understand that the massage therapist does not diagnose illness, and, as such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulation. I am aware that this massage is not a substitute for medical examination/diagnosis and that it is recommended that I see a physician for any ailment that I may have. I understand and I agree that I am receiving massage therapy entirely at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy, I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Aches Away may request credit card information to hold appointments in situations where clients have missed appointments and do not call to cancel within 24 hours.

Signed: _____ Date: _____