ONCOLOGY
CLIENT HEALTH INFORMATION

Name: _____ Phone:_____

Address: _____

Emergency Contact: _____ Phone:_____

Physician: _____ Referred by:_____

Email: _____ Age:_____

Type of Cancer and Location_____

Date of Diagnosis _____ Current Blood Counts _____

Are you being treated now? Y N

If yes, how ? _____

Results from treatment(s) _____

If no, when did you finish treatment? _____

Have you ever had lymph nodes biopsied/radiated/removed?_____

If yes, where? _____

Current Medications: _____

Previous Surgeries? _____

Current major complaints _____

Physical Pain _____

Overall Energy _____

Symptoms related to Chemotherapy/Radiation/Surgery (Please check those that apply)

____ Fatigue	____ Neuropathy	____ Change in Appetite
____ Nausea/Vomiting	____ High/Low Blood Pressure	____ Decreased Taste
____ Hair Loss	____ Sensitivity to Lotions/Oils	____ Thirst
____ Bone Density Loss	____ Bladder Problems	____ Dry Mouth and Skin
____ Irritability	____ Digestive Problems	____ Weight Loss
____ Depression	____ Poor Wound Healing	____ Edema/Lymphedema
____ Emotional Upset	____ Skin Problems	____ Easy Bruising
____ Muscle Aches, region	____ Mouth Sores	____ Infection of _____
_____	____ Insomnia	_____

Others:

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner, so that the pressure may be adjusted to my level of comfort. I further understand that massage or bodywork 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 of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I stated all my known medical conditions and answered all questions honestly. I will inform the practitioner of any changes in my medical profile, and understand that there is no liability on the practitioner's part should I fail to do so.

_____ _____

Signature of Client Date