All Is Well
MASSAGE & SPA
Healing Hands to Pamper You

ONCOLOGY INTAKE/CONSENT FORM

Name:_____Today's Date: _____

Type of Cancer:_____Date Diagnosed: _____

TYPE OF TREATMENT

1) Surgery/Procedure: Yes ☐ No: ☐

If Yes, Where: _____

2) Radiation: Yes ☐ No: ☐

If Yes, Where:_____Date of last treatment: _____

3) Chemotherapy: Yes ☐ No: ☐ Date of last treatment: _____
4) Other: _____
5) Medical Devices (what type/where): _____
6) Have you had lymph nodes removed? Yes ☐ No: ☐

If Yes, How many/Where: _____

7) Current medications for any other conditions:_____

_____

8) Please check any side effects that apply: Nauseous ☐ Weak/Fatigued ☐ Skin Conditions ☐
Swelling ☐ Tenderness ☐ Numbness ☐ Inflammation ☐

Please describe: _____

9) Do you have any position restrictions? Yes ☐ No: ☐
If yes, please describe where:_____

10) Do you have any site restrictions due to:

___incisions, open wound, drains or dressings
___skin sensitivity, rash or skin condition
___bone/spine metastasis
___history/risk of blood clots or phlebitis
___infected area
___other:_____
___IV port, ostomy, catheter
___a tumor site
___radiation site
___neuropathy
___fracture history

11) Do you have any pressure restrictions due to:

___history of Lymphedema ___fatigue ___low platelet count
___anticoagulants ___steroid meds ___fragile/sensitive skin
___bone/spine metastasis ___fragile veins ___fever/infection
___area of pain/burning ___recent surgery
other:_____

12) Are there any other medical conditions that we should be aware of?

_____
_____
_____

I understand that I will be receiving massage therapy as a form of adjunct health care only and that this therapy is not intended to replace appropriate medical care. If at any point I experience any complications or changes in my condition, I will notify All Is Well Holistic Spa.

I release the practitioners and their insurers, and their respective officers, directors, stockholders, successors, employees and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving massage therapy.

I understand that it is my responsibility to provide a doctor's note indicating that I have medical clearance to receive massage if I have received diagnosis/treatment within the past six months and/or any lymph nodes have been removed.

My signature below affirms that I have read and agreed to the consent information that was presented to me.

Signature_____**Date**_____

Print Name_____

Therapist Notes: