Concordia Wellness, LLC ONCOLOGY HEALTH INTAKE FORM

Name _____ Pronouns _____

Address _____

Phone _____ Email _____

Date of Birth _____ How did you hear about us? _____

Emergency Contact Name & Phone _____

What are you hoping to gain from massage? _____

_____

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

Where is/was it located? _____

Are you being treated now? Y N If no, what was the last date of your treatment?_____

In the past year, what cancer treatments have you undergone?

_____

_____

Medications/ Nutritional Supplements	Reason Taken	Side Effects
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Other Medications/Supplements: _____

Has your treatment included any removal or irradiation of lymph nodes? Y N If yes, where?

_____

To your knowledge, do you have any **site restrictions** Y N **pressure restrictions** Y N

or **position restrictions** Y N ?

Has cancer or cancer treatment affected the function of any of the following in your body (*circle any that apply*):

lungs liver nervous system heart kidneys blood counts energy level

Do you experience any of the following (*circle any that apply*):

sites of pain or tenderness swelling or tendency to swell anywhere in your body

sites of numbness or diminished sensation inflammation

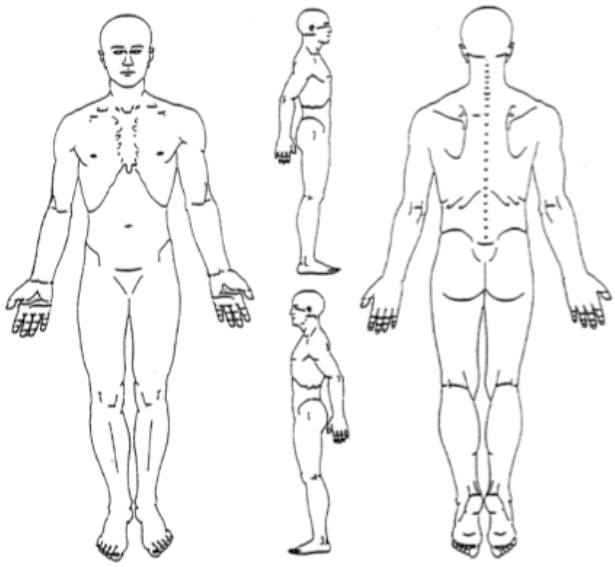
Indicate any of the following conditions that you have now or have had in the past:

▫ High/Low blood pressure	▫ Embolism/Deep-Vein Thrombosis	▫ Diabetes
▫ Skin conditions	▫ Heart/Circulatory problems	▫ Stroke
▫ Liver or kidney conditions	▫ History of trauma	▫ Osteoporosis
▫ Allergies/Sensitivities	▫ Acute anxiety/Depression	▫ Asthma
▫ Blood clotting conditions	▫ Respiratory or lung conditions	

Are you experiencing pain today? Y N

If yes, how long have you had this pain? _____

Indicate on this diagram where you are experiencing pain:



Other than the aforementioned, do you have any illnesses or symptoms of illness? Y N

Have your exercise, sleep, or eating routines changed recently? Y N

How many hours per day do you . . .

exercise? _____ sit at a computer? _____ sleep? _____

Are you able to relax? Y N What do you usually do to relax?

_____

_____

☐ ***Send me occasional (not frequent) informative emails including our stellar quarterly newsletter***

Consent

I understand that there are conditions for which massage therapy may be contraindicated. I have completed this Health Intake Form truthfully and to the best of my knowledge and I have transmitted any recommendations and restrictions on the part of my medical doctor or therapist insofar as bodywork is concerned. I understand that with any treatment certain risks are involved and that complications or side effects could occur. I freely assume these risks, and I agree that I will not hold Concordia Wellness, LLC, or Massage Therapists practicing at Concordia Wellness, LLC, liable for any effects from my session.

Client Signature _____ Date _____