

Shine Therapy Massage Intake Form

General Information

Name _____ Today's Date _____

Gender ____ Age _____ DOB _____ Referring Oncologist _____

Address _____ County _____

Phone _____ (home) _____ (cell) Email _____

For Funding Purposes:

Household size _____ Annual Income _____ Ethnicity _____

Do you have health insurance? _____ If yes, does it cover the majority of your cancer related expenses? _____

Oncological Medical History

Exact Diagnosis, including metastases location _____

Are you currently in Treatment? Yes No

Surgery

Please provide date(s) and type of surgery (s), and results if applicable.

Lymph node removal- Answer if lymph nodes were removed.

How many were removed? _____ Positive or Negative? _____

Have you had any swelling, heaviness, or discomfort in the involved limb? _____

Have you ever been treated for lymphedema? _____ If yes, when and where? _____

Chemotherapy

Please provide the start and end dates of chemotherapy. Please provide the schedule if in active treatment and the name of the drugs being administered.

Start _____ End _____ Schedule _____

Drugs _____

Do you have a portacath? _____ If so, where? _____

Blood Work-Answer below, are your results low, high, or normal? Are you taking Neupogen, Procrit, or other medicines to build or alter your blood counts?

Hemoglobin _____ platelets _____ WBC's _____

Radiation

Please provide the start and end dates of radiation. Please provide the schedule if in active treatment.

Start _____ End _____ Schedule _____

Do you have burns, blisters, or other skin reaction to radiation? _____

Additional Medical History

Type of Condition	Receiving Care?	Type of Condition	Receiving Care?
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Skin Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Varicose Veins or Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			

If you have had any additional physical accidents, traumas, or surgeries, please list them here

Allergies

Do you have any allergies to lotion ingredients, including nut oils? _____ latex? _____

Other allergies _____

Medications

Please list all medications currently taking

Pain Rating

Physical- On a 0-10 scale with 0 being no pain, and 10 being the worst pain possible, please rate the pain you are experiencing today and note the location as well. _____

Emotional-On a 0-10 scale with 0 being no distress, and 10 being the worst stress possible, please rate the stress/anxiety level you are experiencing today. _____

Disclosure

I understand that massage therapy is given here for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation or energy flow. I understand that the massage therapist does not diagnose illness or disease and therefore does not prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. Massage therapy is not for sexual gratification. The therapist will maintain appropriate draping at all times. Therapist will not engage in breast massage of female clients. Area of massage application and technique will be discussed and agreed upon with both myself and massage therapist. If at any time I am uncomfortable with the massage, I should ask the therapist to stop, change techniques, or end the massage. I have stated that all my known medical conditions and taken it upon myself to keep the therapist updated on my health status.

Signature: _____

Date: _____

