ONCOLOGY CONSENT FORM

Name	Date

HEALTH HISTORY

Please check all current / past conditions that apply:

Type of Cancer:	Date of Diagnosis:
Type of Treatment: ☐ Surgery ☐ Chemotherapy ☐ Radiation (Please provide entry/exit sites): ☐ Other:	
Dates and Location of Treatment(s):	
Describe any side effects/reactions from treatments:	
Please check any/all that apply: ☐ Fatigue ☐ Incisions ☐ Nausea ☐ Blood Clots ☐ Bruising ☐ Skin Conditions ☐ Medical Devices ☐ Uncomfortable Positions	
Please explain:	
Have you had any lymph nodes removed? ☐ Yes ☐ No If yes, please list locations:	
If you have an issue you do not wish to state on this form, please discuss it with your therapist.	
Is there anything we can do to make your massage more comfortable, relaxing and/or enjoyable?	

TERMS & CONDITIONS

BY SIGNING BELOW, I AGREE THAT I HAVE READ AND UNDERSTAND THE FOLLOWING:

My massage therapist at the Studio may or may not be trained and/or experienced in oncology massage. I hereby voluntarily release Operator dba Elements Massage®, Elements Therapeutic Massage, LLC, the franchisor of the Elements Massage™ franchise system, its and their affiliates and their respective shareholders, members, principals, owners, officers, directors, employees, agents, representatives, successors, and assigns from all claims, costs, demands, expenses, and causes of action should my condition be aggravated or reoccur at any time.

DOCTOR'S AUTHORIZATION
If I am still receiving treatment or am under a doctor's care for this condition, I understand I am required to provide, and have therefore provided Operator with, a doctor's authorization to receive massage.

Name of Studio Operator: Elements Massage of Hilliard ***("Operator")***
Studio Address: 3804 Fishinger Blvd , Hilliard, OH 43026 ***("Studio")***

Signature	Print Name	Date	MT Initials

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