elements massage®

ONCOLOGY INTAKE CONSENT

ABOUT YOU

NAME	TODAY'S DATE
TYPE OF CANCER	DATE OF DIAGNOSIS

TYPE OF TREATMENT

☐ Surgery ☐ Radiation (Provide entry/exit sites below) ☐ Chemotherapy ☐ Other:

DATE(S) & LOCATION(S) OF TREATMENT	ENTRY/EXIT SITES (RADIATION ONLY):

DESCRIBE ANY SIDE EFFECTS/REACTIONS FROM TREATMENT

HEALTH HISTORY

PLEASE CHECK ALL THAT APPLY

☐ fatigue	☐ incisions	☐ nausea	☐ bruising
☐ blood clots	☐ skin conditions	☐ medical devices	☐ uncomfortable positions

Please explain:

Have you had any lymph nodes removed?
☐ Yes ☐ No If yes, please list locations:

Is there anything else you feel we should know about?
☐ Yes ☐ No If yes, please explain:

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 experience more comfortable, relaxing and/or enjoyable?

AUTHORIZATION

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

My massage therapist may or may not be trained and/or experienced in oncology massage. I hereby voluntarily release Elements Massage® and any of its' affiliates, franchises, and franchisee therapists from any liability 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 the studio with, a doctor's authorization to receive massage.

SIGNATURE	DATE