**Massage Therapy Consent Form**

*Your answers to the questions on this form are essential to a safe, effective massage therapy session. Please take time to answer in detail and return to us 24 hours before your session.*

**Name: _____ DOB: ____ Sex: M/F Date: _____**

**E-mail Address: _____ Occupation: _____**

**Address:_____ City:_____ State:_____**

**Phone: ( )_____**

**Emergency Name and phone:**

**_____**

**Radiation Oncologist: _____**

**Medical Oncologist: _____**

**Primary Cancer, Stage, Location: _____**
**Previous Cancer or Secondary Cancer: _____**
**Do you have and metastasis (spreading of the cancer)? Y/N Where? _____**

**<u>Treatment</u>**

**Have you had cancer surgically removed? Y/N Date:_____**
**Were lymph nodes removed? Y/N How Many? _____ Where? _____**
**Have any of your health care providers expressed a concern about Lymphedema? Y/N**
**Has anyone explained to you what Lymphedema is? Y/N Who: _____**

**Radiation Therapy: Completed or Undergoing? How many treatments: _____**
**Side Effects: _____**

**Chemotherapy? Y/N Completed or Undergoing? Date of last treatment: _____**
**Side Effects: _____**
**Blood Transfusion in the last 3 months? Y/N When? _____**

**Is your treatment for Cancer on hold for any reason? Y/N Why? _____**

**Blood Clots**

**Have you ever experienced a blood clot or DVT (Deep Vein Thrombosis)? Y/N**
**If yes, please explain: _____**
**Are you currently taking blood thinners? Y/N**

**Medical History (check all that apply)**

| | | |
|---|---|---|
| **___ Heart Disease** | **___ Parkinson's Disease** | **___ Seizures** |
| **___ Muscular Dystrophy** | **___ Cerebral Palsy** | **___ Open Wound's** |
| **___ Multiple Sclerosis** | **___ Shingles** | **___ Crohn's Disease** |
| **___ Asthma** | **___ Irritable Bowel Syndrome** | **___ Nausea** |
| **___ Fibromyalgia** | **___ Diabetes** | **___ Bone Mets** |
| **___ Emphysema/COPD** | **___ Stroke** | **___ Joint Replacement** |
| **___ Neuropathy** | **___ Constipation** | **___ Peg Tube** |
| **___ Depression** | **___ Broken/Fractured Bones** | **___ Shunt** |
| **___ Pacemaker** | **___ Joint Stiffness/Swelling** | **___ Rods/Pins** |
| **___ Surgical Drain** | **___ Spasms/Cramps** | **___ Diarrhea** |
| **___ Disk Reconstruction** | **___ Anxiety** | **___ Osteoporosis** |
| **___ Scoliosis** | **___ PTSD** | **___ Ports/Pic Line** |
| **___ Paralysis** | **___ Implants** | **___ Oxygen Tank** |

**Surgeries**

_____
_____
_____
_____
_____

**Medications**
**List all medications you are currently taking including prescribed, over-the-counter, and herbal/nutritional supplements**

_____
_____
_____
_____

**Pain**
**Do you have any areas of pain? Y/N Where? _____**
**What is the reason for your pain? _____**
**Is this new pain? Y/N**
**Is your physician aware of this pain? Y/N**

**Activity Level**
**In general, what is your activity level?**

| | | |
|---|---|---|
| **___ Bed Rest** | **___ Sedentary** | **___ Occasional exercise** |
| **___ Regular exercise** | **___ Daily exercise** | **___ Competitive athlete** |

**Are you pregnant? Y/N If yes, how far along are you? _____**

**What kinds of physical activities do you engage in regularly?**

_____
_____
_____
_____

**Allergies**

**Do you have any allergies to latex, lotions, oils, or foods? Y/N**

_____
_____
_____
_____

**Massage History**

**Have you ever had a massage before? Y/N**
**What specific things did you like or not like about previous experiences?**

_____
_____
_____

**Are there areas you would like to focus on during this massage?**

_____
_____

**What type of pressure would you prefer? Light, Medium, Firm**
**Individual who completed questionnaire? Patient or Caregiver**

**ACKNOWLEDGEMENT**

**I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort or the session discontinued. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have answered all questions completely and honestly. If any medical condition changes after I begin the massage therapy sessions, I understand it is my responsibility to notify my massage therapist. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist(s), Touch of Lavender LLC (DBA The Art of Touch Therapeutic Massage) or their affiliates should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Massage Therapist will be responsible for determining the type of massage that is appropriate for my**

**medical condition as indicated by my responses above. By signing below, I am consenting to massage therapy and acknowledge that I have received and red the list of contraindications.**

**Client Signature _____ Date _____**

**Witness Signature _____ Date _____**

**Massage Therapist's Signature _____ Date _____**