



ONCOLOGY INTAKE CONSENT

CORE VITAL MASSAGE THERAPY & WELLNESS

ABOUT YOU	NAME		TODAYS DATE	
	TYPE OF CANCER		DATE OF DIAGNOSIS	
	TYPE OF TREATMENT <input type="checkbox"/> Surgery <input type="checkbox"/> Radiation (Provide entry/exit sites below) <input type="checkbox"/> Chemotherapy <input type="checkbox"/> 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			
	<input type="checkbox"/> fatigue	<input type="checkbox"/> Incisions	<input type="checkbox"/> nausea	<input type="checkbox"/> bruising
	<input type="checkbox"/> bloodclots	<input type="checkbox"/> skin conditions	<input type="checkbox"/> medical devices	<input type="checkbox"/> uncomfortable positions
	Please explain:			
	Have you had any lymph nodes removed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list locations:			
	Is there anything else you feel we should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
If you have any issues 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 Core Vital Massage Therapy & Wellness, and it's 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	