Tayonon Holistics

Tayonon Holistics Oncology Massage Intake Form

Name: _____ DOB/Age: _____ Date: _____

Address: _____

Email: _____Phone: _____

Type of Cancer, Stage, Location: _____

Date of Diagnosis: _____ Is the cancer currently active? _____

Are you in treatment now? YES/NO If no, when did you finish treatment? _____

Oncologist Doctor's Name/Hospital Name: _____

Last visit _____ How often do you see your doctor? _____

Treatment Review

Surgery: ☐ YES/NO ☐ Describe: _____
Date:

Side effects: Fatigue ☐ Nausea or Vomiting ☐ Temporary Pain ☐
Appetite changes ☐ Bruising or Swelling ☐ Lymphedema ☐
Constipation or Diarrhea ☐ Cording (Axillary Web Syndrome) ☐
Infection ☐ Scar Issues ☐
Any other side effects _____

Chemotherapy: YES/NO Number of Treatments: _____
Dates:
Side effects: Fatigue ☐ Nausea or Vomiting ☐ Temporary Pain ☐
Appetite changes ☐ Bruising or Swelling ☐ Lymphedema ☐
Constipation or Diarrhea ☐ Chemo Brain ☐ Alopecia (Hair Loss) ☐
Mouth, Gum, Throat Problems ☐ Weight loss/gain ☐
Neuropathy (hands or feet) ☐ Pain, numbness or tingling ☐
Any other side effects _____

Radiation: YES/NO Area/Rounds of Treatments: _____
Dates:
Side effects: Fatigue ☐ Nausea or Vomiting ☐ Temporary Pain ☐
Appetite changes ☐ Mouth sores ☐ Skin irritation ☐ Insomnia ☐

Lymphedema _____ Memory problems _____
Constipation or Diarrhea _____
Neuropathy (hands or feet) _____ Pain, numbness or tingling _____

Any other side effects _____

Any other treatments (bone marrow transplantation) or therapies (hormone, etc.)?

Did your treatment include any removal or radiation of lymph nodes? YES/NO
If yes, please explain.

Have you experienced lymphedema? YES/NO If yes, please explain.

Have you experienced deep vein thrombosis (blood clots)? YES/NO If yes, please explain.

Has cancer or cancer treatment affected any of the following? (indicate by placing an "x")

_____ Lungs _____ Liver _____ Nervous system _____ Heart _____Kidney
_____Blood Counts _____ Energy Level _____ or any others not listed? (please explain)

Do you know your current blood count? YES/NO If yes, what is it? _____

Current Medications (for cancer or other condition not described above):

Current Nutritional Supplements and Herbs:

Have you tried any complementary and alternative methods for cancer management? YES/NO If yes, please explain.

Describe your energy level today (1-5, 5 being the highest).

Site Restriction Questions.
Do you have any

_____ incisions, open wounds, drains or dressings _____ new pain or discomfort
_____ skin sensitivity, rash or skin condition _____ other (please explain)
_____ IV, port, ostomy, catheter, breast expander/prosthesi
_____ a tumor site _____radiation site _____neuropathy _____ lymph node removal or

☐ bone or spine metastasis ☐ fracture history radiated
☐ area of infection ☐ history/risk of blood clot

Pressure Adjustment Questions.

Please indicate if any of the following apply to you.

☐ history or risk of lymphedema (circle one or both)
☐ lymph node removal/radiated
☐ neuropathy in hands or feet
☐ anticoagulants
☐ bone or spine metastasis
☐ fragile/sensitive skin
☐ area of pain or burning
☐ recent surgery
☐ easy bruising
☐ low platelet count
☐ steroid medication
☐ fragile veins
☐ fatigue
☐ infection or fever
☐ bone fragility/density loss
☐ other (please explain)

Positioning Modification Questions.

When you are on the massage table, should I make any positioning adjustments for you because of

☐ incisions ☐ medications ☐ tumor site ☐ tender skin
☐ breathing difficulty ☐ not feeling comfortable with a certain position
☐ swelling or risk of swelling (any body area that needs to be elevated?)
☐ medical devices (please describe) _____
☐ discomfort (please describe) _____

Do you have any of the following? If yes, please explain.

Skin conditions _____

Known allergies _____

Cardiovascular conditions (high/low blood pressure, varicose veins, blood clots, history of heart condition) _____

Liver or Kidney conditions _____

Respiratory or Lung conditions _____

Diabetes _____

Injuries (back, neck, hip or knee) _____

Arthritis or joint problems _____

Digestive problems _____

Other Surgeries _____

Informed Consent:

I, _____, do hereby request and give permission to receive, massage and/or manual lymphatic drainage therapy from Tayonon Holistics LLC, and any Licensed Massage Therapist working with them. I understand that I have the right to inquire about and refuse any part of the treatment.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment to be in my best interest based on the known facts at the time. Although I am aware that massage therapy has helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

Policies & Procedures:

Appointment Reminders and Follow Up Communication
We may use or disclose your health information to provide you with appointment reminders and follow up communication via phone, voicemail, email or letter.

Privacy Practices
I have reviewed Tayonon Holistics LLC's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Payment

- Payment is due at the time of service. We accept cash, checks, and most major credit cards.
- Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 business hours notice you will be charged a $50 fee.
- We reserve the right to change our fee scale without notice.

I have completed this form to the best of my knowledge. I have read and understand the informed consent, privacy, and procedures information. By signing below I agree to a course of treatment in massage therapy and intend this consent form to cover the entire course of treatment for my present condition as well as any future condition(s) for which I seek treatment with this practice.

_____
Patient's Name (please print)

_____ _____
Patient's Signature Date

_____ _____
Signature of Massage Therapist Date