Metta Oncology Massage

Medical History Form (Page 1 of 2)

Name	Date of birth	Today's date (v3.8)
Address	Employer	Home phone
City/State/Zip	E-mail address	Work phone
Emergency contact and phone	Who referred you for massage?	Cell Phone

Health Care Information

Primary health care provider		Other provider and modality	
Address		Address	
Telephone	Date of last visit	Telephone	Date of last visit
Current diagnosis or treatment		Current diagnosis or treatment	

May I consult confidentially with your health care provider(s) if it would be helpful? ***Please initia*l**: Yes_____No_____

Current Medications (prescription, over-the-counter, and herbal) Please include dosage & frequency if known:

Personal Medical History Please **(CIRCLE)** conditions experienced within the last 12 months and **UNDERLINE** older conditions.

Skeletal broken/fractured bone bursitis arthritis tendonitis osteoporosis joint/bone pain other

Muscular sprain/strain spasm/cramp headache neck/shoulder/arm pain low back/hip/leg pain jaw pain/TMJ other

Circulatory heart condition high/low blood pressure varicose veins blood clots edema lymphedema phlebitis other

Digestive constipation diarrhea gas/bloating diverticulitis irritable bowel syndrome indigestion/reflux ulcer other

Nervous numbness/tingling chronic pain herpes/shingles headache migraine fatigue sleep disorder carpal tunnel other

Skin allergy rash warts athletes foot plantar-wart difficult scaring other

Reproductive pregnancy #___ PMS Breast: injury pain congestion/swelling internal scarring fibrocystic other

Respiratory breathing difficulty sinus problems allergies asthma other

Other chemical sensitivity contagious disease anxiety depression diabetes drug/alcohol eating disorder food sensitivity

aids hiv positive nicotine/caffeine implant/prosthesis contact lens pacemaker

Additional Page(s) Attached Cancer Headache Fibromyalgia Multiple Sclerosis Parkinson's Breast Other_____

May you be at peace. May your heart remain open. May you awaken to the light of your own true nature.
May you be healed. May you be a source of healing to all beings ……. The metta of the Buddha

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Name	**Medical History (Page 2 of 2)**	Today's date (v3.8)

Surgeries (except cancer related), significant accidents or major injuries: Please describe: Year

Lifestyle

Single or Partner?	Does anyone else live with you?	Ages of children?	Do you have pets?
Physical activities at work?	Do you exercise? How often?	What do you do to relax?	Do you sleep well? Position?
Do you smoke? (amount per day)	Alcohol? (amount per week)	Height	Weight

Touch History

Have you experienced emotional, physical or sexual abuse?_____

Are there areas of your body that are touch sensitive? _____ If so, in what way?_____

A female breast may be treated to facilitate recovery from surgery or radiation, to improve scars, to relieve general discomforts, or simply for a more complete massage experience. The nipple and areola are not touched. Please indicate which, if any, you are interesting in learning more about: ___Surgical or radiation recovery ___Improve scars ___General discomforts ___Complete experience ___Not at this time.

The pubic area, genitals and the gluteal cleft are not uncovered or touched.
Are there any other areas you do not want massaged? _____

Approximately how many massages have you had?_____ How long since your last massage?_____

What did you like best about them?_____ Least?_____

What are your reasons for receiving massage now?_____ Are you allergic to any lotions or oils?_____

Consent

It is my choice to receive massage therapy. I recognize that treatment is given for the wellbeing of body and mind. This includes stress reduction; relief from muscular tension, spasm and pain; increased circulation and energy flow. I understand that I can stop or modify the treatment at any time and agree to communicate with my therapist immediately should I feel my wellbeing is being compromised.

I, _____, understand that massage therapists do not diagnose illness, disease, or any mental or physical disorder; do not prescribe medical treatment or pharmaceuticals; and do not perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that I must see a physician for those services.

If I have cancer or a chronic disease, I have previously consulted with my physician about massage and I have informed my massage therapist of any suggested limitations and restrictions.

I have stated all medical conditions of which I am aware, including communicable disease, and I will promptly inform my massage therapist of any change in my health status.

Signature_____ Date_____

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