647 Wyoming Ave.
Kingston, PA 18704
570-283-0111
www.thrivewellnesskingston.com

Massage Therapy/Reflexology/Reiki
Acknowledgement & Treatment Consent
For Persons Living With Cancer

I, _____ (Client/Patient) understand that the practice of massage therapy for the person living with cancer is performed for stress reduction and to assist relaxation. I understand that the massage therapist does not diagnose illness, disease or any other physical disorder. As such, the massage therapist does not prescribe or perform medical treatment or spinal manipulation. It has bee made clear to me that massage therapy does not substitute for medical examination or treatment. Because a massage therapist must be made aware of existing physical conditions, I take it upon myself to keep the massage therapist updated on my physical health. I have, to the best of my knowledge, stated all of my known medical information.

By signing this form, client's attending physician acknowledges receipt of information that the above mentioned client does intend to receive massage therapy for the above stated purpose.

Client and doctor agree to inform the massage therapist of any condition which may be a contraindication for the practice of massage therapy.

_____	_____	_____
Client/Patient (Please print)	Client/Patient (Please sign)	Date
_____	_____	_____
Attending Physician (Please print)	Attending Physician (Please sign)	Date
_____	_____	_____
Massage Therapist (Please print)	Massage Therapist (Please sign)	Date

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DOCTOR INFORMATION

GP Name: _____ GP Phone:_____
Oncologist:_____ Oncologist Tel: _____

MEDICAL INFORMATION

Medical Alert: _____ If yes, detail: _____
Allergies: _____ If yes, detail: _____
Height: _____ Weight: _____
Type(s) of Cancer:_____ Locations: _____
Date of Diagnosis: _____ Currently Under Treatment? Y _____ N_____

Surgery: Y ____ N ____ Body Areas: _____ Date _____
_____ Date _____
_____ Date_____

Radiation: Y _____ N ____ Body Areas: _____
Last treatment date: _____ _____
_____

Lymphedema: Y _____ N ____ Body Areas: _____
Last treatment date: _____ _____
_____

Chemotherapy: Y _____ N ____ Body Areas: _____
Last treatment date: _____ _____
_____

Chemotherapy Names: _____
_____

Any Treatments you are Receiving other than those Listed Above: Y ____ N ____ If Yes, What Types: _____
_____
_____

On a scale of 1 to 10, please Describe your pain level: Y ____ N ____ Pain Locations(s): _____
_____

Has cancer/cancer treatment affected you in any of the areas below? If yes, please detail.

Blood Count: Y ____ N ____ Details: _____
Energy Level: Y ____ N ____ Details: _____
Heart: Y ____ N ____ Details: _____
Kidneys: Y ____ N ____ Details: _____
Liver: Y ____ N ____ Details: _____
Lungs: Y ____ N ____ Details: _____
Nervous Syst: Y ____ N ____ Details: _____
Bladder: Y ____ N ____ Details: _____
Bowel: Y ____ N ____ Details: _____

GENERAL SIGNS AND SYMPTOMS/OTHER MEDICAL CONDITIONS

Do you suffer from any of the following anywhere in or on your body? If so, please detail.

Swelling/Tendency to Swell: Y ____ N ____ Details: _____
Sites of Pain or Tenderness: Y ____ N ____ Details: _____
Areas of Inflammation: Y ____ N ____ Details: _____
Skin Rashes, Itching, Infection: Y ____ N ____ Details: _____
Cardiovascular Conditions: Y ____ N ____ Details: _____
Blood Pressure: Y ____ N ____ Details: _____
Liver or Kidney Conditions: Y ____ N ____ Details: _____
Respiratory or Lung Issues: Y ____ N ____ Details: _____
Diabetes: Y ____ N ____ Details: _____
Arthritis or Joint Problems: Y ____ N ____ Details: _____
Digestive Problems: Y ____ N ____ Details: _____
Surgeries: Y ____ N ____ Details: _____

MASSAGE/LYMPHEDEMA/REFLEXOLOGY/REIKI HISTORY

Have you had massage therapy before? Y ____ N ____ If yes, what type: _____
What aspects of treatment did you like most? _____
What aspects of treatment did you like least? _____

Have you had manual lymph drainage before? Y ____ N ____
What aspects of treatment did you like most? _____
What aspects of treatment did you like least? _____

Have you had reflexology before? Y ____ N ____
What aspects of treatment did you like most? _____
What aspects of treatment did you like least? _____

Have you had Reiki before? Y ____ N ____
What aspects of treatment did you like most? _____
What aspects of treatment did you like least? _____

POSITION/SITE RESTRICTIONS

Do you have any site restrictions due to any of the following? If yes, please detail.

Incisions:	Y ____	N ____	Details: _____
Open Wounds:	Y ____	N ____	Details: _____
Drains of Dressings:	Y ____	N ____	Details: _____
Neuropathy:	Y ____	N ____	Details: _____
Area(s) of Infection:	Y ____	N ____	Details: _____
Rash:	Y ____	N ____	Details: _____
Skin Condition(s):	Y ____	N ____	Details: _____
Tumor Site(s):	Y ____	N ____	Details: _____
Bone or Spine Metastasis:	Y ____	N ____	Details: _____
IV Port, Ostomy, Catheter:	Y ____	N ____	Details: _____
Radiation Site:	Y ____	N ____	Details: _____
History/Risk of Blood Clots:	Y ____	N ____	Details: _____
Swelling:	Y ____	N ____	Details: _____
Difficulty Breathing:	Y ____	N ____	Details: _____
General Discomfort:	Y ____	N ____	Details: _____
Others:	Y ____	N ____	Details: _____

PRESSURE RESTRICTIONS

Do you have any pressure restrictions due to any of the following? If yes, please detail.

Fatigue:	Y ____	N ____	Details: _____
Bruise Easily (Low Platelets):	Y ____	N ____	Details: _____
Neutropenia:	Y ____	N ____	Details: _____
Neuropathy in Hands or Feet:	Y ____	N ____	Details: _____
Fragile/Sensitive Skin:	Y ____	N ____	Details: _____
Fragile Veins:	Y ____	N ____	Details: _____
Area(s) of Pain or Burning:	Y ____	N ____	Details: _____
Infection or Fever:	Y ____	N ____	Details: _____
Lymph Node Removal in Axilla, Neck, or Groin:	Y ____	N ____	Details: _____
Bone Density Loss:	Y ____	N ____	Details: _____
Other(s):	Y ____	N ____	Details: _____

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INFORMED CONSENT

The above information is accurate to the best of my knowledge and I freely give my permission for massage, manual lymph drainage, reflexology, or Reiki treatment. I agree to inform the therapist of any discomfort during the session. I agree to update the therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget or neglect to do so. I agree to hold harmless the therapist, Thrive Wellness Center, and all personnel, from and against all claims.

I have informed my attending physician(s) that I intend to receive massage, manual lymph drainage, reflexology, or Reiki treatment from my attending practitioner at Thrive Wellness Center, and that his/her/their signature(s) acknowledging their approval on the physician permission document are genuine. Permission from medical personnel shall be valid for six months from date of signature.

In addition, I understand that any type of massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that Massage / Touch Therapists and/or body workers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any mental or physical ailments. For any mental or physical ailments, I will seek advice from a physician, or other qualified specialist.

I understand that my attending therapist will keep all treatment and diagnosis information confidential as per Thrive Wellness Center's Confidentiality Agreement, unless so authorized by me.

Client Name (Printed) : _____

Client Signature: _____ Date _____