Shane Selby
Licensed Massage Therapist
Certified Lymphedema Therapist

200 Donelson Pike
Nashville TN 37214
(931) 260-5991 / m.s.selby@live.com
http://shanes-fusion-therapy.abmp.com

Client Health History Form

Name ________________________________ Date ________________________

Street Address ________________________________ City, State Zip ________________________

Telephone # ________________________ Email Address ____________________________

Date of Birth __________ Emergency Contact Name/Telephone ________________________

1. Have you had Massage Therapy before? **Yes** **No** If yes, was there anything you liked or didn't like?

   ____

2. What kind of activities are you able to participate in? ________________________________
   Please give us a general idea of your current day-to-day or week-to-week activities, if any.

   ____

3. When were you first diagnosed with cancer? ________________________________

   What type of cancer? ________________________________

   Is cancer currently active? ________________________________

   Where was/is it located? ________________________________

4. Are you being treated now? **Yes** **No** If no, what was the date of your last treatment? __________
   NOTE: if you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of the massage session, please have your physician complete the MD permission form.

5. What ***treatments*** have you undergone, when? ***Please list dates and types of surgery and other treatments.***

6. Current ***medications*** (for cancer or other condition) not described above:

7. Did your treatment include any removal or radiation of lymph nodes? ***(If yes, please describe where)*** ______

   ____

8. Did your treatment include radiation therapy? ***(If yes, please describe where)*** ________________

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9. Do you have any ***site restrictions*** due to:

____ Incisions, open wounds, drains or dressings
____ Skin sensitivity, rash or skin condition
____ IV, port, ostomy, catheter, or other device ***(circle)***
____ A tumor site
____ Radiation site
____ Neuropathy
____ Bone or spine metastasis
____ Fracture history
____ Area of infection
____ History/risk of blood clot
____ Other ***(please describe below)***

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10. Do you have any ***pressure restrictions*** due to:

____ History or risk of lymphedema ***(circle which)***
____ Anticoagulants
____ Low platelet count
____ Bone or spine metastasis
____ Steroid med
____ Fragile/sensitive skin
____ Fragile veins
____ Area of pain or burning
____ Fatigue
____ Recent surgery
____ Infection or fever
____ Other ***(please describe below)***

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11. Do you have any ***position restrictions*** due to:
____ Incision
____ Medication
____ Ostomy
____ Tumor site
____ Difficulty breathing
____ Tender skin
____ Swelling or risk of swelling (any body area need elevating?)
Please describe ____________________
____ Medical devices
Please describe ____________________
____ Discomfort
Please describe ____________________

12. Has cancer or cancer treatment affected any of the following functions in your body? ***(circle current issues)***

____ Lungs
Please describe ____________________
____ Liver
Please describe ____________________
____ Nervous system

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Please describe ____________________

____ Heart
Please describe ____________________

____ Kidney
Please describe ____________________

____ Blood counts
Please describe ____________________

____ Energy Level
Please describe ____________________

General Signs and Symptoms

Check "yes" and add comments if you have or have had any of the following:	***Yes***	***No***	***Comments***
13. Any ***swelling*** or ***tendency to swell*** anywhere in your body?			
14. Any sites of ***pain*** or ***tenderness*** anywhere in your body?			
15. Any sites of ***numbness*** or ***reduced sensation*** anywhere in your body?			
16. Any areas of ***inflammation***?			

Other Medical Conditions

Check "yes" and comments if you have or have had any of the following:	***Yes***	***No***	***Comments***
17. ***Skin conditions*** *(rashes, infections, itching)*			
18. Known ***allergies*** or ***sensitivities*** *(if you use any physician-approved or well-tolerated lotion on your skin, please bring it for us to use with you)*			
19. ***Cardiovascular conditions*** *(History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)*			
20. ***Liver or Kidney conditions*** *(for example: kidney failure, hepatitis, portal hypertension, etc.)*			
21. ***Respiratory or Lung conditions***			
22. ***Diabetes*** *(describe type, any medication, whether blood sugar is well-controlled, any complications.)*			
23. ***Injuries*** *(any back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures)*			
24. ***Arthritis or Joint problems***			
25. ***Digestive problems***			
26. ***Surgery***			