Compassionate Therapies
Meg Robsahm, M.Ed., LMP, NCTMB
www.CompassionateTherapies.com
425-422-8455

Health History Information

Name: _____ Today's Date: _____
Address: _____ Home Phone: _____
_____ Work Phone: _____
_____ Cell Phone: _____
Date of Birth: _____ Emergency Contact: _____
Occupation: _____ Phone for E.C.: _____

Primary Health Care Provider(s)

Name PHP: _____ Additional PHP: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

I give my manual therapist permission to consult with my health care providers regarding my health and treatment. Initials: _____ Date: _____

Massage History

Have you had massage therapy previously? No Yes
Was there anything you liked or disliked? _____
What do you expect from your massage during cancer treatment? _____
_____

Current Cancer History

Type of Cancer: _____ Date of Diagnosis: _____
Location: _____ Staging at time of Dx: _____
Mets? No Yes Location: _____
Previous cancers if any: _____

Treatment Approaches:

Are you currently being treated? No Yes Date of last Treatment: _____
How are you being treated? Please list dates, types, and location of treatment: _____
_____

If your treatment included, please provide:

- Lymph node removal: Location: _____ Number removed: _____
- Radiation: Location: Location: _____ Side effects if any: _____

Medications

Please list any medications and supplements you are currently taking below:

Medication or supplement name:	Purpose:	Dosage:

Side effects

Pressure related side effects:

☐ Easy bruising
☐ Fatigue
☐ Low white count (neutropenia)
☐ Neuropathy hand/feet
☐ Recent Hx of blood clots
☐ Lymph node removal
☐ Radiation neck/Axillary/pelvis
☐ Edema
☐ Osteoporosis
☐ Metastases
☐ Fragile/sensitive skin areas
☐ Limb w/central line
☐ Anticoagulant meds
☐ Recent surgery

Position related adjustments:

☐ Radiation burn
☐ Hx or risk of Lymphedema
☐ Site or risk of swelling
☐ Nausea
☐ Tumor
☐ Incision
☐ Medical devices
☐ Breathing difficulty

Site related restrictions:

☐ Pain or discomfort
☐ Incisions
☐ Skin problems
☐ Areas of unusual warmth
☐ Recent Hx of blood clots
☐ Tumor
☐ Metastases or Hx of Fx
☐ Medical devices
☐ Area of infection: _____
☐ Radiation site: _____

Please list any other side effects that may require adjustments for massage:

_____
_____
_____

Please describe your fatigue level:

☐ I'm doing great
☐I can't get out of bed
☐ I'm okay, but not quite myself
☐ Other: _____

Additional Medical Conditions

Check and comment on any of the following conditions that you have had or are currently experiencing:

☐ Skin Conditions (rashes, allergies, infections):_____
☐ Known allergies or sensitivities: _____
☐ Cardiovascular (angina, artherosclerosis, arteriosclerosis, blood clots, High/low blood pressure, heart disease, stroke): _____
☐ Liver or kidney Conditions: _____
☐ Respiratory or lung Conditions: _____
☐ Diabetes or thyroid Conditions: _____
☐ Immunological conditions (Lupus, Fibromyalgia): _____
☐ Muscular or joint disorders: _____
☐Injuries: _____
☐ Surgeries: _____

Contract and consent for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team and my experiences with those suggestions. I promise to inform my practitioner any time I feel my well being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ Date _____
Received HIPAA Statement (Please initial) _____ Date _____
If minor, signature of parent or guardian _____ Date _____