Pure Bodywork Therapies

405 2nd St., South Suite C
Safety Harbor, FL 34684
727.946.2068

Health/Lifestyle History

Name_____

Mailing Address (please include zip code)_____

_____

Daytime phone _____

Mobile Phone _____

Email address _____

Date of birth ____/____/_____

Should you choose to continue to receive massage therapy services from Pure Bodywork Therapies, I will normally contact you 24-48 hours before your next appointment to confirm. In what manner would you prefer to be contacted? By phone _____; by email____; by text message _____; no preference, any of these is fine _____

Emergency Phone Contact (Name and Phone) _____

_____

What is your occupation? _____

Had you ever received bodywork before your cancer diagnosis? _____ If so, what types?

_____

Have you received bodywork since your cancer diagnosis? _____ If so, when and what types? _____

Do you see a chiropractor? If so, how often? _____

Why have you come for massage today?

_____

Is there anything specific that you hope to achieve through massage?

_____

When were you diagnosed with cancer? _____ What type of cancer? _____

Where is/was it located? _____

Are you being treated now? Yes No If no, what was the last date of your treatment?

_____

What **treatments** have you undergone or are you currently undergoing? *Please supply dates and types of treatments to the best of your ability.* (please list on top of next page)

_____

_____

_____

Please list any **medications** you are currently taking, in addition to any chemotherapy drugs listed above, and any **side effects** you experience.

Medication **Side Effect**

Did your treatments include any **removal or irradiation of lymph nodes**? *(if yes, please describe)*

To your knowledge, do you have any **site restrictions** due to :

____*incisions, open wounds, dressings*

____*skin condition, rash or sensitivity*

____*medical devices such as IV or ostomy*

____*tumor site* ___ *radiation site(s)*

____*a history of blood clots or phlebitis*

____*bone or spinal metastases* ____*neuropathy*

____*history of fractures* ____*bone fragility*

____*area of infection* _____*other (please describe)* _____

To your knowledge, do you have any **pressure restrictions** due to:

____*history of risk of lymphedema*

____*anticoagulants* ____*low platelet count* ____*bone metastases*

____*steroid medication* ____*fragile/sensitive skin* ____*fragile veins*

____*area(s) of pain or burning* ____*fatigue* ____*recent surgery*

____*infection or fever* ____*other (please describe)* _____

Do you have any **position restrictions** due to:

____incision ____medication ____ostomy ____tumor site ____difficulty breathing ____tender skin

____swelling or risk of swelling *(any area of the body require elevating?) please describe*

_____

Medical devices _____

Discomfort _____

Has cancer or cancer treatment affected any of the following functions in your body?

___lungs ___liver ___nervous system ___heart ___kidney ___blood counts ___energy level

If yes, please describe _____

_____

General Signs and Symptoms

Check "yes" & add further comments if you have had any of the following sign/symptoms	**Yes**	**No**	**Comments**
Swelling or tendency to swell anywhere in your body			
Sites of pain/tenderness			
Sites of numbness/diminished sensation			
Inflammation			

Specific Medical Conditions

Check "yes" & add further comments if you have had any of the following sign/symptoms	**Yes**	**No**	**Comments**
Skin conditions (rashes, infections, allergies, itching)			
Known **allergies/sensitivities** (Do you use any non-allergenic or physician-approved lotion?)			
Cardiovascular conditions (e.g. heart condition, angina, high blood pressure, ateriosclerosis, phlebitis, thrombosis, etc)			
Liver or **kidney** conditions			
Respiratory or **lung conditions**			
Diabetes			
Arthritis			
Injuries (e.g. disc problems, tendonitis, knee problems, fractures, etc)			
Surgery			
Any conditions NOT MENTIONED			

How would you rate your **diet**? Very Healthy _____ Somewhat Healthy _____

Not Very Healthy _____ Needs Improvement _____

How much uninterrupted **sleep** do you get each day, on average? _____ none ____1-3 hours ____ 4-5 hours ____ 6-7 hours ___ 8+ hours

If you are having trouble sleeping, what is the primary reason? ____ anxiety ___pain ____outside interruption (family, noise, etc) ____other *(please explain)*_____

On average, how much **water** do you drink each day? (as a reference, a soft drink can contains 12 oz.) Less than one 8oz. Glass _____

More than five 8oz. Glasses _____ Eight or more 8oz. glasses _____

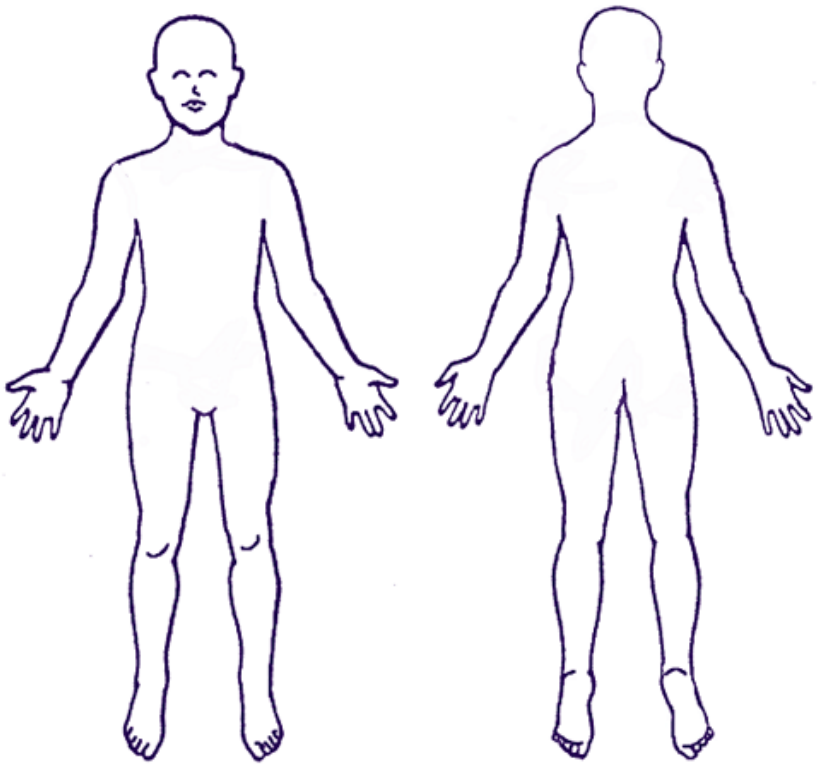
Are you **able to relax**? Yes No If so, What do you usually do to relax?

_____

Is there **anything else** that you think I should know? _____

_____

Please indicate any areas of discomfort or pain on the diagrams below. Rate your discomfort in each area using a scale of 1-10. 1= very mild ; 10= extreme, intrusive pain



Feel free to make notes next to any areas of pain that you feel require explanation.

Statement of Policy

Some Basic Boundaries to Clarify How We Can Best Work Together to Create an Effective, Cooperative Healing Relationship:

I will adhere to the Code of Ethics set forth by the American Massage Therapy Association (AMTA) and maintain a professional and caring environment. ALL information you provide, both written and verbally, will remain completely **CONFIDENTIAL** unless you have signed a "Release of Information" form.

I will treat you fairly and ethically, and will establish an atmosphere of trust, care and decency during each session from the moment you enter my office until the moment you leave. I ask only the same from you.

As a massage therapist, my goal is to assist you in meeting your goals of *relaxation, stress reduction, pain management, body awareness, and integration of mind, body and spirit* as well as any other goals you and I set out that fall within my scope of practice and knowledge. It is important to understand that ***I neither "diagnose" nor "fix" clients***. I am neither trained in, nor practice, the medical sciences.

I reserve the right to refuse or discontinue service at any time, for any reason, in an effort to ensure my own safety and the safety of my clients. You have the same right.

Patient Consent for Treatment
Please read and sign below.

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Client Signature _____ **Date** _____
Practitioner Signature _____ **Date** _____

If under 17, signature of parent/guardian_____ **Date**_____

Thank you!