Well of Life Center
FOR NATURAL HEALTH

New Client Intake Form

for Oncology Massage

Your answers to the questions on this form are essential for a safe, effective massage therapy session. Please take some time to answer in detail, and have this paperwork **completed** prior to the start of your appointment.

Oncology Massage Intake Form

Client Information

First Name _____ MI _____ Last _____

Home Phone _____ Cell Phone _____

Street Address _____

City _____ State _____ Zip _____

Birthdate _____

Have you had a massage therapy before? ____ Yes ____ No

If yes, what did you like or dislike about your previous massage? _____

_____

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

Where was/is it located? _____

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

NOTE: If you are currently in treatment, or if your last treatment session was less than 12 months ago, please have your physician complete the Physician's Permission Form.

Physician's Name _____ Physician's Phone # _____

May we contact your physician? ____ Yes ____ No

What treatments have you undergone? *Please supply detail, with dates and types of cancer treatments; attach another paper if necessary.*

_____

_____

Current medications not described above: _____

_____

Did your treatment include any removal or radiation of lymph nodes? ____ Yes ____ No

If yes, please describe where _____

Did your treatment include radiation therapy? ____ Yes ____ No

If yes, please describe areas of your body affected _____

Do you have any site restrictions due to:

___ incisions, open wounds, drains, or dressings ___ history or risk of blood clots or phlebitis

___ IV, port, ostomy, catheter, or other device *(if yes, circle which)* ___ skin sensitivity, rash, or skin condition

___ tumor site ___ radiation site ___ neuropathy ___ bone or spine metastasis

___ fracture history ___ area of infection ___ other: _____

Do you have any pressure restrictions due to:

___ history or risk of lymphedema *(if yes, circle which)* ___ fatigue ___ low platelet count

___ bone or spine metastasis ___ fragile/sensitive skin ___ fragile veins ____ recent surgery

___ area of pain or burning ___ steroid medication ___ anticoagulants ___ infection or fever

___ other: _____

Do you have position restrictions due to:

___ incision ___ medication ___ ostomy ___ difficulty breathing ___ tender skin

___ swelling or risk of swelling *(if yes, describe)* _____

___ medical devices *(if yes, describe)* _____

___ discomfort *(if yes, describe)* _____

Does any body area need elevating? ____ Yes ____ No

If yes, please describe _____

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

___ lungs ___ liver ___ nervous system ___ heart ___ kidney ___ blood counts ___ energy level

Please describe any you have marked above: _____

_____

_____

General Signs and Symptoms

Check "yes" or "no" and add comments if you have or have had any of the following:	**Yes**	**No**	**Comments**
Swelling or tendency to swell anywhere in your body			
Sites of pain or tenderness anywhere in your body			
Sites of numbness or reduced sensation anywhere in your body			
Areas of inflammation			

Other Medical Conditions

Check "yes" or "no" and add comments if you have or have had any of the following:	Yes	No	Comments
Skin conditions (rashes, infections, itching)			
Known allergies or sensitivity *(if you use any physician-approved lotion on your skin, please bring it for the massage therapist to use)*			
Cardiovascular conditions (for example: heart condition, high blood pressure, angina, hardening of the arteries, history of stroke, severe varicose veins, blood clots)			
Liver or kidney conditions (for example: kidney failure, hepatitis, portal hypertension, etc.)			
Respiratory or lung conditions			
Diabetes (describe type, any medication, whether blood sugar is well-controlled, any complications)			
Injuries (any back problems, knee problems, tendonitis, disc injuries, neck problems, recent fractures)			
Arthritis or joint problems			
Gastrointestinal problems			
Surgery			

We reserve the right to refrain from providing a massage service, until written permission is given by your medical professional.

Important note: It is my choice to receive massage therapy. I understand that the information given above is strictly confidential and will be used for no other purpose than to assist the massage therapist in providing a suitable massage which would take into consideration my specific requirements. I also understand that failure to disclose all my known medical conditions could result in injury and/or illness. I hereby release Well Spa and Well of Life Center for Natural Health, LLC, from any claims resulting in such. Any information provided to me by the massage therapist is for general purposes only and is not intended for any medical or therapeutic purpose.

Client Signature: _____ Date: _____

AGREEMENT AND RELEASE OF LIABILITY

The health and nutritional information you receive from any Well of Life Center Clinician or employee, or independent contractor, whether given by phone, in person at your home, in a Well of Life Center office, through lectures, workshops, brochures, emails, or newsletters is not intended to diagnose, prescribe, treat, cure, alleviate, prevent or care for any disease in any way. It consists of combined information from many educational sources and points of view to help you make informed decisions regarding your desired level of health. The sources behind this information include: modern medicine, ancient Chinese medicine, naturopathic medicine and the therapist's personal research, study, and life observation as well as client results and experiences. Anyone deciding to act upon any information mentioned during a consultation shall assume full responsibility for any effects of their actions. There are risks and unforeseen results associated with any change of diet and lifestyle. It is not recommended that you apply these changes unless you are willing to assume full responsibility for the risks you choose to take. If you choose to implement dietary and lifestyle changes without consulting your physician, which is your constitutional right, you are, in effect, prescribing for yourself. When in doubt of the appropriateness of any treatment, whether recommended to you by a clinician or by your own intuition, please consult a physician. Consultation information should not be used as a substitute for a physician's advice. It is our hope that you do choose a physician who realizes the importance of a healthy diet and lifestyle choices in correcting imbalances in the body and who has experience in treating immune disorders and other health imbalances. Please be aware that you have the right to make your own health decisions based on any information made available to you. **YOU are the driving force in guiding yourself on a path to health!**

ACKNOWLEDGEMENT

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by the clinicians or employees or independent contractors of the Well of Life Center for Natural Health, LLC is to be used for educational purposes only. I also acknowledge that neither Well of Life Center for Natural Health, LLC, Cynthia Hofmann-Coale, Victoria Fisher, Felicia Pasquale, Christine Haines, Alicia Leonhardt, Kate McNerney, Jon Gindhart, Ashley Stalmack, Emily Urie, members of the massage department, members of the fitness department, estheticians, nor any of the staff members at the Well of Life Center for Natural Health or Well Spa claim to be medical doctors and will not prescribe for or diagnose, treat, prevent, alleviate or cure any disease or condition. Well of Life Center for Natural Health, LLC and its nutritional clinicians have been thoroughly trained and certified.

If I experience any changes in my health or current medications, I will immediately communicate this information to Well of Life Center for Natural Health, LLC. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold Well of Life Center for Natural Health, LLC liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that Nutrition Response Testing is not a method for "Diagnosing" or "Treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

In consideration of being allowed to participate in programs, modalities, and activities of Well of Life Center for Natural Health, LLC. and to use its facilities in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Well of Life Center for Natural Health, LLC and its members, directors, officers, agents, employees, representatives, successors and assigns, administrators, executors, affiliated independent contractors, and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery. I do also hereby release all of these mentioned and any others acting upon their behalf from any responsibility or liability from any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Well of Life Center for Natural Health, LLC.

I have read and understand the foregoing. Intending to be legally bound, I hereby release the Well of Life Center for Natural Health, LLC from any liability, including for negligence, regarding my health matters and my participation in Nutrition Response Testing or any other program offered at or through the Well of Life Center for Natural Health, LLC. This release applies to all subsequent visits for programs, modalities and activities at the Well of Life Center for Natural Health, LLC.

Client Name (print):_____

Signature: _____ Date:_____

Client, Parent, or Personal Representative