THE TEAL CENTER
For Therapeutic Bodywork, Ltd.

Health/Lifestyle History

Name_____

Mailing Address (please include zip code)_____

_____

Daytime phone _____

Mobile Phone _____

Email address _____

Date of birth ____/____/_____

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.*

_____

_____

_____

turn page over

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 ____medicaiton ____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

turn page over

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 _____

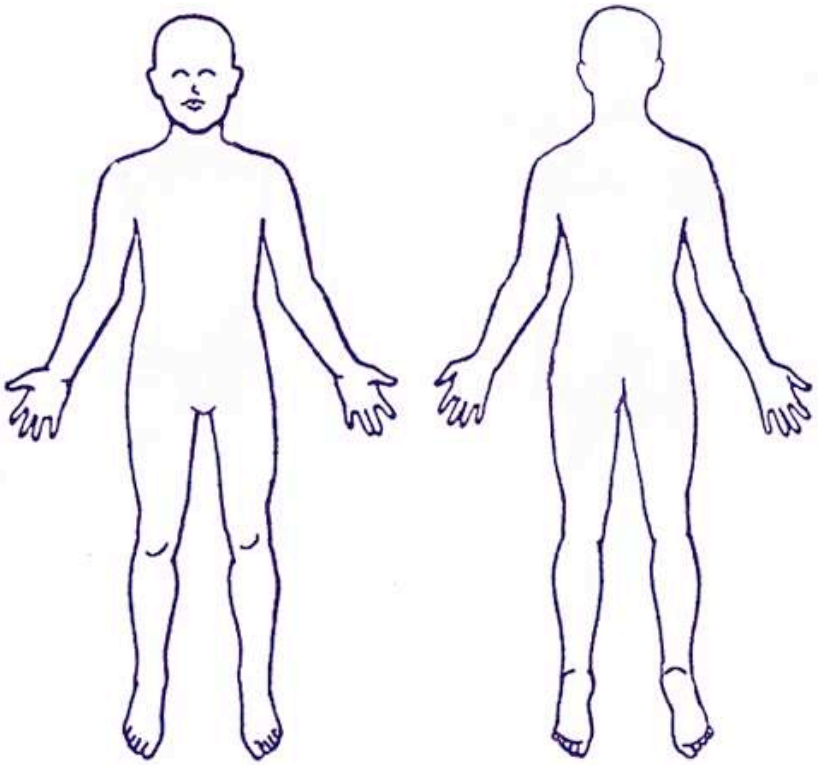
Are you **able to relax**? Yes No If so, What do you usually do to relax?

_____

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.

Thank you!