LotusVoice Integrative Therapies, LLC
Health Intake Information
Date _________________________

Client Contact Information

Client Name: ____________________________________ Date: ____________
Date of Birth: ____________ Gender: ____________
Address:
____
Phone: ______________________________ Email: ___________________________
Referred by: ____________________________________
Emergency contact: ______________________________ Phone: ___________________________
Family Doctor/ Physician/Health-care Provider name: ________________________
Phone:__________________
Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)?
Yes □ No □
Do you have a physician referral/prescription? Yes □ No □

Massage Information

Have you ever received professional massage/bodywork before? Yes □ No □
How recently? ____________________________________
What types of massage/bodywork do you prefer? ____________________________________
What kind of pressure do you prefer? Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork?
____
____
How do you feel today?
____
List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):
____
Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
Explain:
____
____

Are you wearing contacts? Yes □ No □
Are you wearing dentures? Yes □ No □
Are you wearing a hairpiece? Yes □ No □
Are you pregnant? Yes □ No □

**Oncology History

When were you diagnosed?_______________________

What type of cancer?________________________________

Where was it located?____________________________

What is the present status of your cancer?_________________

Who is your oncologist?____

Date of last visit?_________________

How often do you see your oncologist?_______________________

Surgery/Procedure:

Type ____
Date________________ Lymph nodes removed: Number_______
Where:____
Reconstruction: Date(s)/Procedure(s):
____

Side Effects:
____

Chemotherapy:

Number of Treatments:_______ Beginning Date:________ End:________

Number of Treatments:_______ Beginning Date:________ End:________

Number of Treatments:_______ Beginning Date:________ End:________

Side Effects:
____
____

Radiation:

Number of Treatments: ________ Beginning Date: _________ End: _________

Area of Treatment _____________________________________ Nodes Irradiated in the neck, armpit, or groin? Yes No

Number of Treatments:________ Begin Date:_________ End:_________

Area of Treatment ______________________________________ Nodes Irradiated in the neck, armpit, or groin? Yes No

Side Effects:

____

____

Other: Please list any other treatments:

____

____

____

____

Has any doctor said anything to you about lymphedema? Yes No

bone metastases? Yes No

Medical Devices: IV catheter port breast expander urinary catheter ostomy
feeding tube (PEG) breast prosthesis Other_________________________________

Side Effects: (Circle) current conditions. Underline past conditions. ❒Check here if explanation below

GI Conditions: nausea, vomiting, low appetite, mouth sores, wt. loss, wt. gain, diarrhea, constipation

Musculoskeletal: Osteoporosis, bone pain, adhesions, incision, decreased range of motion or function, pain, former injuries, factures, joint problems, joint replacement, headache, touch/pressure sensitivity

Nervous System: burn/itch/tingle/prickle/numbness in arms/hands/legs/feet, memory problems

Skin: skin, infection, dry skin, fragile skin, skin irritation, radiation skin reaction, hair loss

Circulatory/Blood: edema, easy bruising, low platelet, low white count, blood clot, excessively cold/warm, lymphedema, heart condition, high blood pressure, lung condition

General: fatigue, depression, anxiety, allergies, systemic infection, infectious condition

Other: current tumor, enlarged nodes/spleen/liver, radioactivity, other____________________________

Explanations: (as needed)

____

____

Is there anything else you would like Therapist to know?

____
____
____
____
____

Current Medications:

Drug name	Purpose	Side Effects

Date _________________________

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. 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. Understanding all of this, I give my consent to receive care.

Client Signature: ____
Date: ____________

Parent or Guardian Signature (in case of a minor): ___________________________________
Date: ____________