Viride massage & bodywork studio

Oncology Wellness Form

ABOUTYOU

Name	Today's Date
Type of Cancer	Date of Diagnosis

Type of Treatment

☐ Surgery ☐ Radiation (provide entrance/exit sites) ☐ Chemotherapy ☐ Other

Describe any side effects/reactions from treatment	Date of treatments

HEALTHHISTORY

Have you had any lymph nodes removed? ☐ Yes ☐ No	Please list locations

Please check all that apply

☐ Fatigue ☐ Blood clots ☐Incisions ☐ Nausea

☐ Skin Conditions ☐ Medical Devices ☐ Bruising ☐ Uncomfortable positions

Is there anything else you feel we should know about? ☐ Yes ☐ No

Is there anything we can do to make your massage experience more comfortable, relaxing and/or enjoyable?

If you have an issue you do not wish to state on this form, please discuss it with your therapist.

AUTHORIZATION

By signing below, I agree that I have read and understand:

My massage therapist may or may not be trained and/or experienced in oncology massage. I hereby voluntarily release
Viride massage & bodywork studio from any liability should my condition be aggravated or reoccur at any time.

Doctor's Authorization

If I am still receiving treatment or am under a doctor's care for this condition, I understand I am required to provide, and have therefore provided the studio with, a doctor's authorization to receive massage.

SIGNATURE	DATE