

**Donna Menezes-Enos LCMT**  
**Acupuncture Plus Massage Holistic Center**  
**11079 Spring Hill Drive**  
**Spring Hill Florida 34606**  
**352-683-9499**

[www.AcupuncturePlusMassage.com](http://www.AcupuncturePlusMassage.com)

*Your answers to the questions on this form are essential for a safe and effective massage.  
Please take some time to answer in detail these questions presented to you.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone # \_\_\_\_\_

DOB \_\_\_\_\_ Contact Info \_\_\_\_\_

\_\_\_\_\_

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1- Have you had massage therapy before? **YES / NO** If yes was there anything that you liked or did not like ?

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2- Have you had massage therapy since your cancer diagnosis and treatment? If yes please explain how it was tolerated, was it vigorous, deep tissue etc.

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3- When were you first diagnosed? \_\_\_\_\_ What type of Cancer? \_\_\_\_\_

4- Where was/is the Cancer located on your body? \_\_\_\_\_

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5- 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 mos. Ago please have your physician complete the accompanying permission form.*

6- What treatments have you undergone? Please supply details with dates and types

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7- Current Medications, not described above: \_\_\_\_\_

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8- Did your treatments include any removal or radiation of Lymph nodes. (If yes please describe here)

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9- Do you have any site restrictions due to :

Incisions, open wounds, drains or dressings

Skin sensitivity, rash or skin condition

IV, port, ostomy, catheter or other device (circle)

Tumor site                       Radiation site

Bone or spine metastasis       Neuropathy

Fracture History                 Area of infection

History or risk of blood clots or phlebitis

Other (Please Specify)

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10- Do you have any pressure restrictions due to :

History or risk of lymphedema

Anticoagulants                       Low platelet count

Bone or spine metastasis             Steroid Medication

Fragile/sensitive skin                 Fragile Veins

Area of pain or burning               Fatigue

Recent surgery                         Infection or fever

Other

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11- Do you have any positions restrictions:

Incision    Medication    Ostomy    Tumor site    Difficulty Breathing    Tender Skin

Swelling or risk of Swelling (any body area that needs elevating) Please describe

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Medical devices Please describe \_\_\_\_\_

Discomfort Please describe \_\_\_\_\_

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

Lungs    Liver    Nervous system    Heart    Kidney    Blood Counts    Energy Level

Check any that apply and describe

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## Cooperative Care Plan

Dear \_\_\_\_\_

Your Patient \_\_\_\_\_ has expressed an interest in receiving massage therapy during the course of her/his Cancer treatment. I am writing to you to:

- 1- Outline some common cautions I use when working with people in cancer treatment
- 2- Seek your input on which cautions should be in force with this Client.

**My Techniques with most Clients:** I use kneading and Stroking techniques and apply compressions to the tissues with my hands. I might also do passive stretching and range of motion. I can apply a range of pressures, from just moving the skin (like lotioning) to deeper muscular work.

**Common Adaptations for Clients in Cancer treatment:**

**Sites** affected by surgery, radiation therapy, IV's, drains, skin conditions, pain , edema, or bone involvement . We will avoid pressure and often contact at these sites. If there is any nodal involvement with risk of lymphedema, we will use only minimal pressure on the distal extremity and gentle pressure on the trunk quadrant. If needed, the limb will be elevated during he massage.

**Low Platelet levels: easy bruising:** We will use gentle strokes that displace skin and other superficial tissues, not deep muscle layers.

**Side-effects:** Treatments such as chemotherapy and radiation therapy  
We will work gently in order to avoid aggravating fatigue, nausea, etc., and will adapt other elements of the session to any presenting side-effects.

**Deep Vein Thrombosis:** Any risk, secondary to malignancy, inactivity or cancer treatment  
We will avoid all use of pressure on areas at risk of thrombosis in those areas.

\_\_\_\_\_ has my permission to receive a relaxation Massage described above.

I have read through the common massage therapy adjustments, above. I have circled any concerns for this patient. If I have additional concerns for the massage practitioner, I have described them below \_\_\_\_\_

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date

**General Medical Signs and Symptoms.** Please indicate if you *currently* have any of the following conditions.

Symptom		Yes	No	Location: Please describe
1	Any areas of infection?			
2	Any areas of swelling, edema or tendency to swell?			
3	Any areas of numbness or Altered sensation?			
4	Any areas of pain or tenderness?			

**Specific Medical Conditions.** Therapeutic massage may affect these and your health. For your safety, our therapists must be aware of *all medical conditions*.

Condition		Yes	No	Please Describe
5	Arthritis			
6	Cancer or Tumors			
7	Cardiovascular Diseases			<i>Please circle all that apply:</i> anemia, angina, arteriosclerosis, congestive heart failure, heart attack, heart murmur, hemophilia, hypertension, varicose or spider veins, other (please describe):
8	Diabetes			
9	Injuries			
10	Kidney, Liver or Urinary problems			
11	Respiratory Conditions			
12	Skin Conditions			<i>Please circle all that apply:</i> acne, abrasions/cuts, birthmarks/moles, bruises, dermatitis, eczema, herpes, hives, poison ivy/oak/sumac, psoriasis, skin tags, sunburns, warts, other (please describe):
13	Surgery			Date of Surgery: Describe:
14	Gastrointestinal Problems			
Other Medical Conditions not mentioned above				

**Please read and sign:**

*I verify that all information provided is correct and current to the best of my knowledge. I understand that any information provided by the student/therapist is for educational purposes only and is not prescriptive or diagnostic in nature. I hereby give my consent to receive therapeutic massage in the Therapy Center and will not hold the Muscular Therapy Institute, the Therapy Center or my student/therapist responsible for any personal injury or loss of property.*

Signature \_\_\_\_\_

Date \_\_\_\_\_