



Massage Profile & Release Form

All information will be kept confidential and used only by service professionals.

Name (Last, First, M.I.) _____ Date _____

Please list any pain, that you have, either reoccurring or recent. Where is it located?

Is discomfort/pain constant or does motion increase the pain? _____

What type of movements increases the pain? _____

When did the problems start and what activity caused it? _____

Are you under a physician's care: ____ For what condition: _____

Are you currently taking any medication(s): _____

Have you had a massage before: _____

Have you consumed caffeine or alcohol _____

If yes how much and how long ago? _____

Do you smoke ____ How much: _____

Occupation: _____

Goals for massage _____

In case of Emergency, Contact?

Name _____

Phone _____

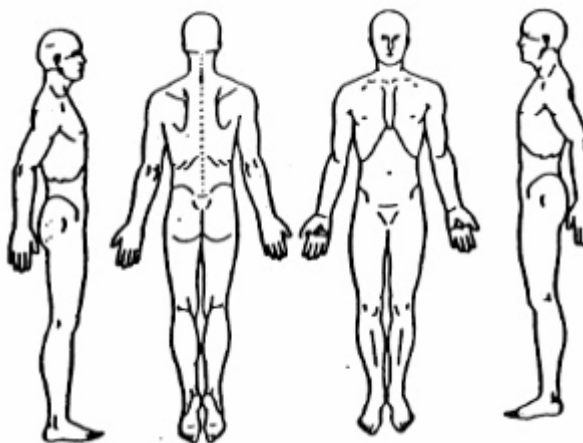
Do I have permission to contact your physician? _____

Name _____ Phone _____

If you have or had a history of any of the following, please check and give details below. Include any scars or operations.

- ___ Arthritis
- ___ Asthma
- ___ Blood clots
- ___ **Cancer (TURN OVER SHEET)**
- ___ Carpal Tunnel Syndrome
- ___ Contagious Diseases
- ___ Fibromyalgia
- ___ Fractures
- ___ Heart problems
- ___ High blood pressure
- ___ Lacerations
- ___ Lower back pain
- ___ Migraines
- ___ Pregnant Due date _____
- ___ Skin Diseases
- ___ Surgery _____ Date _____
- ___ TMJ
- ___ Upper back pain
- ___ Varicose Veins
- Other: _____

Please X areas of discomfort / pain. Then number next to the X on a scale of 1-10, 10 being the most painful.



I understand that the services offered are not a substitute for medical care and any information provided is for educational purposes only not diagnostically prescriptive in nature.

Client Signature _____ Date _____

Professional Signature _____ Date _____

Please fill this side out so your therapist can customize your massage to benefit your time here at Dolce. Thank You

1. Type of cancer and location _____ Date of Diagnosis _____

2. What is the present state of your cancer _____

3. Are you being treated now? Yes No

If yes, how? _____

If no, when did you finish treatment? _____

What type of treatment? _____

What areas of the body? _____

4. Do you have any side effects as a result of treatment?

Pressure-related side effects:

_____ easy bruising (could be due to meds or low platelets)

_____ fatigue

_____ low white count (neutropenia)

_____ recent Hx of blood clots

_____ neuropathy in the hands or feet

_____ lymph node removal

_____ radiation Tx to neck, axillary area, or pelvis

_____ edema

_____ bone fragility

_____ metastases

_____ areas of fragile or sensitive skin

_____ limb with central line

_____ other: _____

Site-related restrictions:

_____ pain or discomfort

_____ incisions

_____ area that feels unusually warm

_____ recent Hx of blood clots

_____ skin problems

_____ metastases or Hx of Fx

_____ other: _____

Positioning Adjustments:

_____ tumor

_____ medical devices

_____ incisions

_____ other: _____

_____ medical devices

_____ tumor

_____ nausea

_____ radiation burn

Please turnover when finished and complete form.