Megan Belanger, LMT, CLT, NCTMB
The Healing & Wellness Center
45 Lyman Street, Suite 22
Westborough, MA 01581

508-986-8601
megan@meganbelanger.com
www.meganbelanger.com

Client Health History Form

Client Name: _____ Date of Birth: _____

Address: _____

Telephone Number(s): _____Email Address: _____

Referred by: _____

1. Have you ever had massage therapy before? **YES NO**
If yes, was there anything that you liked or didn't like?

2. When were you first diagnosed with cancer? _____ What type of cancer/stage? _____

3. Where was it located? _____

4. Are you being treated now? **YES NO**
If no, what was the date of your last treatment? _____

5. What treatments or surgeries have you undergone? Please supply details with dates and types of cancer treatments and/or surgeries. Please use the back of the sheet, if needed.

6. What are your blood counts, if you know them: _____

7. Current medications, not described above:

_____ _____

_____ _____

_____ _____

8. Has your treatment included any removal or irradiation of lymph nodes?
If **YES**, please describe.

9. Has your treatment included radiation therapy?
If **YES**, please describe.

10. Do you have any Site Restrictions due to
___ incisions, open wounds, drains or dressings
___ skin condition, rash or sensitivity
___ a tumor site ___ a radiation site
___ a history or risk of blood clots or phlebitis
___ bone or spinal metastases ___ neuropathy
___ history of fractures ___ area of infection
___ other (please describe):

11. Do you have any Pressure Restrictions due to:
___ history or risk of lymphedema
___ anticoagulants ___ low platelet count
___ bone metastasis ___ steroid medication
___ fragile/sensitive skin ___ fragile veins
___ area of pain or burning ___ fatigue
___ recent surgery ___ infection or fever
___ other (please describe):

Please continue to second page

Symptom	Yes	No	Location (describe)
Any areas of infection?			
Any areas of swelling, edema, or tendency to swell?			
Any areas of numbness or altered sensation?			
Any areas of pain or tenderness?			

For your safety, your therapist must be aware of all medical conditions. Therapeutic massage may affect these and your health:

Condition	Yes	No	Please Describe
Arthritis:			
Cancer or Tumors:			
Cardiovascular Disease:			**Please circle all that apply**: Anemia, Angina, Arteriosclerosis, Congestive Heart Failure, Heart Attack, Heart Murmur, Hemophilia, Hypertension, Varicose or Spider Veins, Other: _____
Diabetes:			
Injuries:			
Kidney, Liver, or Urinary Problems:			
Respiratory Conditions:			
Skin Conditions:			**Please circle all that apply:** Acne, Abrasions/Cuts, Birthmarks/Moles, Bruises, Dermatitis, Eczema, Herpes, Hives, Poison Ivy/Oak/Sumac, Psoriasis, Skin Tags, Sunburns, Warts, Other: _____
Surgery:			**Date of Surgery(s):** **Describe:**
Gastrointestinal Problems:			
Other Medical Conditions not mentioned above:			**Please describe:**

Client Consent and Waiver

I understand that I will be asked questions regarding my physical state including present condition as well as past medical history. I understand that there are certain medical conditions for which massage therapy would be contraindicated and that I may need to obtain written permission from my physician before receiving treatment. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I am concurrently working with my Primary Caregiver for any condition I may have. I verify that all information provided is correct and current to the best of my knowledge and will keep the therapist updated on any changes.

All information disclosed will be kept strictly confidential by the therapist. I give my consent to receive therapeutic massage and will not hold my therapist, Megan Belanger, LMT, CLT responsible for any personal injury or loss of property. I am aware that the massage therapist does not diagnose illness or disease, nor prescribe medications or supplements. I understand that payment is due at the time of service. Appointments that are canceled within 24 hours of the scheduled session will result in a charge for the full price of the treatment session scheduled. Emergency cancellations may be determined at the therapist's discretion. Thank you and enjoy!

Signature:_____ Date:_____

Print Name:_____