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The Healing and Wellness Center at Chauncy Place
Phone 508-241-2110
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Client Health History

Full Name: _____ Date: _____

Home phone: (___)_____

Cell phone: (___)_____

Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Male / Female Age: _____ DOB: _____

Have you had a therapeutic massage before? Yes / No

What is the amount of tension in your life? 0….1….2….3….4….5….6….7….8….9….10
(none) (average) (extreme)

What physical activities do you do on a daily or weekly basis?

_____

Please circle any painful or tense areas that you tend to hold your stress:

Head/Face Low Back Shoulders Neck Abdomen
Legs/Feet Arms/Hands Mid-back Other: _____

Are you currently under a Physicians care for a specific condition? Yes / No

If yes, for what condition(s)? _____

If you are in active cancer treatment or have a history of cancer treatment less than 5 years ago, skip to the Cancer Health History part of this form at the end.

Have you recently taken any medications or drugs that alter sensation?
(e.g pain medication, muscle relaxants, alcohol or other depressants or stimulants)

_____

Have you had any of the following health issues in the past year?

Allergies: _____
Angina
Asthma
Blood Clots
Cancer
Carpal Tunnel Syndrome
Communicable diseases
Disk Problems
Fibromyalgia
Heart Disease
Hepatitis
Herpes Simplex
Hospitalization
Hypertension
TMJ or tendency to grind teeth
Immune system conditions
Irritable Bowel Syndrome
Insomnia
Migraines / Headaches
Phlebitis / Thrombosis
Repetitive Strain Injuries
Sciatica
Stroke
Surgery
Varicose Veins
Whiplash
Other: _____

GENERAL MEDICAL SIGNS AND SYMPTOMS:

Do you currently have any of the following conditions?

Symptom:	**Yes**	**No**	**Comments**
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 CONDITIONS:

Condition:	**Yes**	**No**	**Comments**
5. Arthritis			
6. Cancer or Tumors			
7. Cardiovascular Diseases			**Circle all that apply**: Anemia, Angina, Arteriosclerosis, Congestive Heart Failure, Heart Attack, Heart Murmur, Hemophilia, Hypertension, Varicose or Spider Veins, Other: _____
8. Diabetes			
9. Injuries			

10. Kidney, Liver or Urinary problems			
11. Respiratory Conditions			
12. Skin Conditions			**Circle all that apply**: Acne, Abrasions/Cuts, Bruises, Dermatitis, Eczema, Hives, Poison Ivy/Oak/Sumac, Psoriasis, Sunburn, Warts, Other: _____
13. Surgery			Date of Surgery: Describe:
14. Gastrointestinal Problems			
Other Conditions not mentioned above			Please describe:

Cancellation Policy

Out of respect for Nina's time and other's that might be waiting for an appointment, Nina asks that you give at least 24 hrs notice if you must cancel an appointment. If you're feeling sick the day of your appointment, please stay home and consider making a donation to cover the missed appointment. I will not charge you for late cancellation.

COVID Informed Consent

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from Nina Capobianco.

I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Printed Name _____

Signature _____

Today's Date _____

Cancer Health History

1. When were you first diagnosed with cancer? _____

2. What type of cancer? _____

3. Is cancer currently active? _____

4. Where was/is it located? _____

Are you being treated now? Yes No

If NO, what was the date of your last treatment? _____

If YES:

Chemotherapy? Yes No

If YES: What Chemo agents are you on? _____

Are you on Thiotepa and/or Cytoxin37 (aka cyclophosphimide) - if yes, circle

External Beam Radiation? Yes No Where? _____

5. Please list dates and types of surgery and other treatments:

6. Current medications (for cancer or other condition - such as anti-coagulant) not described above:

7. Did your treatment include any removal or radiation of lymph nodes? (If yes, please describe where)

9. Do you have any site restrictions due to:

__ incisions, open wounds, drains or dressings

__ skin sensitivity, rash or skin condition

__ PICC, port-o-cath, colostomy bag, catheter, bladder slings, pelvic mesh, lat band, diabetic pump, or other device (circle)

__ a tumor site

__ radiation site

__ neuropathy

__ bone or spine metastasis

__ fracture history

__ area of infection

__ history/risk of blood clot

__ other -- please describe below:

8. Did your treatment include radiation therapy? If yes, please describe where:

10. Do you have any pressure restrictions due to:

__ history or risk of lymphedema (circle which)

__ anticoagulants

__ low platelet count (Do you know your INR number today? _____)

__ bone or spine metastasis

__ steroid medication

__ fragile/sensitive skin

__ fragile veins

__ area of pain or burning

__ fatigue

__ recent surgery

__ infection or fever

__ other -- please describe below:

11. Do you have any position restrictions due to:

__ incision

__ medication

__ implanted devices please describe _____

__ tumor site

__ difficulty breathing

__ tender skin

__ swelling or risk of swelling (any body area need elevating?) please describe:

12. Has cancer or cancer treatment affected any of the following in your body? (check current issues)

__ Lungs __ Liver __ Nervous system __ Blood counts __ Energy Level

__ Heart __ Kidney

more detail on any of the above:

_____

GENERAL SIGNS AND SYMPTOMS:

Please indicate if you *currently* have any of the following conditions:

Symptom:	**Yes**	**No**	**Comments**
13. Any areas of **inflammation**?			
14. Any **swelling** or **tendency to swell** anywhere in your body?			
15. Any sites of **pain** or **tenderness** anywhere in your body?			
16. Any sites of **numbness** or **reduced sensation** anywhere in your body?			

Other MEDICAL CONDITIONS:

Condition:	**Yes**	**No**	**Comments**
17. **Skin conditions** (rashes, infections, itching)			
18. Known **allergies** or **sensitivities** (if you use any physician-approved or well-tolerated lotion on your skin, please bring with you)			
19. **Cardiovascular conditions** (History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)			**Circle all that apply**: Anemia, Angina, Arteriosclerosis, Congestive Heart Failure, Heart Attack, Heart Murmur, Hemophilia, Hypertension, Varicose or Spider Veins, Other: _____
20. **Liver or Kidney** conditions (for example: kidney failure, hepatitis, portal hypertension, etc.)			
21. **Respiratory** or **Lung conditions**			
22. **Diabetes** (describe type, any medication, whether blood sugar is well-controlled, any complications.)			

23. **Injuries** (any back, neck, hip or knee problems,tendonitis, disc injuries, recentfractures)			
24. **Arthritis or Joint problems**			
25. **Digestive problems**			
26. **Surgery**			Date of Surgery: Describe:

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