



Independently owned and operated by  
**H&S Spa Management, LLC**

## ONCOLOGY INTAKE FORM

I understand that it is my responsibility to provide a doctor's note indicating that I have medical clearance to receive a massage and/or facial, if I have received diagnosis/treatment within the past six months and/or any lymph nodes have been removed within the past 12 months.

### ONCOLOGY INTAKE/CONSENT FORM

Name

Today's Date

Type of Cancer

Date Diagnosed

### TYPE OF TREATMENT

Surgery/Procedure

☐ Yes ☐ No

If Yes, Where

Radiation

☐ Yes ☐ No

If Yes, Where

Date of last treatment

Chemotherapy

☐ Yes ☐ No

Date of last treatment

Other

Medical Devices (what type/where)

Have you had lymph nodes removed?

☐ Yes ☐ No

If Yes, date removed

If Yes, How many/Where:

☐ I understand that Hand and Stone will only perform a light touch massage to the side where the lymph nodes were removed.

Current medications for any other conditions

**Please check any side effects that apply**

- ☐ Nauseous
- ☐ Weak/Fatigued
- ☐ Skin Conditions
- ☐ Swelling
- ☐ Tenderness
- ☐ Numbness
- ☐ Inflammation

**Please describe**

**Do you have any position restrictions**

- ☐ Yes   ☐ No

**If yes, please describe where:**

**Do you have any site restrictions due to:**

- ☐ Incisions, open wound, drains or dressings
- ☐ IV port, ostomy, catheter
- ☐ Skin sensitivity, rash or skin condition
- ☐ Tumor site
- ☐ Bone/spine metastasis
- ☐ Radiation site
- ☐ History/risk of blood clots or phlebitis
- ☐ Neuropathy
- ☐ Infected area
- ☐ Fracture history

☐ Other

**Do you have any pressure restrictions due to:**

☐ History of Lymphedema

☐ Fatigue

☐ Low platelet count

☐ Anticoagulants

☐ Steroid meds

☐ Fragile/Sensitive skin

☐ Bone/Spine Metastasis

☐ Fragile veins

☐ Fever/Infection

☐ Area of pain/Burning

☐ Recent surgery

☐ Other

**Are there any other medical conditions that we should be aware of?**

I understand that I will be receiving massage therapy and/or a facial as a form of adjunct health care only and that this therapy is not intended to replace appropriate medical care. If at any point I experience any complications or changes in my condition, I will notify Hand & Stone Massage and Facial Spa.

I release the practitioners and their insurers, and their respective officers, directors, stockholders, successors, employees and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving a massage and/or facial.

**Hand and Stone Massage and Facial Spas are independently owned and operated franchise locations.**

Notes



POST SURGERY CONSENT FORM

My signature below affirms that I have read and agreed to the consent information that was presented to me.

Print Name :

DATE :

Signature

