It's About You…

The goal of Cherished Friends of Ahava is to *cherish* you. Please take a few moments and respond to the following questions to help us gain insight into what makes you feel special.

As a part of your day, you will receive special attire and customized services. Please share with us this information so that we can ensure your comfort level.

a. Shoe size: _____
b. Robe size:_____

Cherished Friends of Ahava is also interested in *cherishing* the whole person. To enhance your wellness journey, we have researched the effects of specific services and have learned that these have the greatest impact. Please share with us your preference in the areas of sound and scent by circling your choice.

a. Most soothing sound:

Sea Nature Spiritual/Inspirational

b. Most pleasant scent:

Geranium	Green Tea Mint	Lavender
(Calm/Peaceful)	(Uplifting/Energy)	(Soothing/Seductive)

Lastly, your comfort is foremost in the minds of the staff of Cherished Friends of Ahava, especially as you begin your day with us. Therefore, please share with us one thing that you would like us to know about you so that when we greet you at the door, you will feel as if you have just walked into a friend's home.

_____

_____

PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name:_____ Date:_____
Address:_____ Phone:_____
City/State/Zip:_____ Phone:_____
Birthdate:_____ Occupation:_____
Primary Health Care Provider:_____ Phone:_____
Permission to consult with primary provider? Yes____ No_____
Emergency contact:_____ Phone:_____

MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? Yes___ No___
If yes, frequency_____ Date of last massage_____
What results do you want from your massage session?

_____

Prioritize the areas of your body that you would prefer to be massaged.

_____

Are you currently seeing a medical practitioner? Please explain if yes.

_____

Are you currently seeing a psychotherapist or are you attending regular support group meetings?
Please explain if yes _____

_____

List stress reduction exercise activities. Include frequency._____

_____

List current medications including aspirin, Tylenol, etc._____

_____

PREVIOUS HISTORY (include year and treatment received)

Surgeries:_____

_____

Accidents:

_____

_____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my therapist any time I feel like my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of.

SIGNATURE:_____DATE:_____

ASSESSMENT FORM

Client_____Date_____Therapist_____
Type of cancer and location _____Date of Diagnosis_____
Status of cancer now?(remission, localized or spread) _____ Are you currently being treated for your cancer?_____ If yes, please describe (include type of chemo if able): _____ If no, when did you finish treatment:_____
What types of treatment did you receive and to what areas of the body?_____
_____

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

Pressure related:

_____Easy bruising
_____Fatigue
_____Neutropenia
_____Low platelets
_____Sensitive or fragile skin
_____Nausea
_____Neuropathy
_____Fragile veins
_____Weak bones/osteoporosis
_____Edema
_____Fever, chills
_____Central line
_____Lymph node removal or radiation
_____Blood Clots (within 6 month history)
_____ Other_____

Site related:

_____Pain or discomfort
_____Incisions
_____Areas that feel unusually warm
_____Skin problems
_____Medical devices
_____Tumor
_____Recent history of blood clots
_____Bone mets or recent fracture
_____Mets
_____Other_____

Position restrictions:

_____Tumor
_____Medical devices
_____Incision
_____Nausea
_____Radiation induced dermatitis
_____Dyspnea
_____Mucositis
_____Other_____

Briefly describe the session, include description of modalities response from client, and length of session.

HEALTH HISTORY

MUSCULO-SKELETAL
___Bone or joint disease
___ Tendonitis
___ Bursitis
___ Broken/Fractured bones
___ Arthritis
___ Sprains/Strains
___ Low Back, Hip, Leg pain
___ Neck, Shoulder, Arm pain
___ Headaches/Head injury
___Spasms/cramps
___ Jaw pain/TMJ
___ Lupus
___ Other_____

CIRCULATORY
___ Heart Condition
___ Varicose veins
___ Blood Clots
___ High blood pressure
___ Low blood pressure
___ Lymphedema
___ Breathing Difficulty
___ Sinus Problems
___ Allergies
___ Other _____

INFECTIOUS DISEASE
___ Disease name(s):_____
_____

SKIN
___ Allergies
___ Rashes
___ Athletes Foot
___Warts
___ Other_____

NERVOUS SYSTEM
___Herpes/Shingles
___Numbness/Tingling
___ Fatigue
___ Chronic Pain
___ Sleep Disorders
___ Other _____

REPRODUCTIVE
___ Pregnant
___ PMS
___ Other _____

OTHER
___ Cancer/tumors
___ Diabetes
___ Eating Disorders
___Depression
___ Drug/Alcohol addiction
___ Nicotine/Caffeine addiction

DIGESTIVE
___ Constipation
___ Gas/Bloating
___ Diverticulitis
___ Irritable Bowel Syndrome
___ Other_____