Corewell Health

Massage Therapy Patient Intake Form

Part A – Personal Information

Name: _____ **Date:** _____ **MRN:** _____
For Office Use Only

How would you like to be addressed? _____ **Date of Birth:** _____

Preferred Pronouns? _____ **Occupation:** _____

Email Address: _____

Would you like to be added to Integrative Medicine's electronic newsletter email list? Yes: ☐ No: ☐

Have you ever received a professional massage? Yes: ☐ No: ☐

Are you currently taking any pain medication? Yes: ☐ No: ☐

Do you have a history of DVT/blood clots? Yes: ☐ No: ☐

Are you currently taking and blood thinners? Yes: ☐ No: ☐

How is your blood pressure? Low: ☐ Normal: ☐ High: ☐ **Is it controlled by medication?** Yes: ☐ No: ☐

Part B – History of Cancer

Do you have a history of cancer? Yes: ☐ No: ☐ If no, skip to Part C

What is your cancer diagnosis? _____ **Date of diagnosis:** _____ **Stage:** _____
Month/Year

What is your cancer diagnosis? _____ **Date of diagnosis:** _____ **Stage:** _____
Month/Year

Did the cancer metastasize? Yes: ☐ No: ☐ **Did you have lymph nodes removed?** Yes: ☐ No: ☐

If yes, where were the lymph nodes removed from? _____

Which side were the lymph nodes removed from? Left: ☐ Right: ☐ Both: ☐

How many lymph nodes were removed? _____

Do you suffer from heaviness or swelling in the affected arm/leg? Yes: ☐ No: ☐

Did you receive lymphedema education? Yes: ☐ No: ☐

Did you have chemotherapy? Yes: ☐ No: ☐

Chemotherapy start date? _____ **Most recent chemotherapy treatment date?** _____

Are you being given oral chemotherapy? Yes: ☐ No: ☐

Chemotherapy access? Port: ☐ Shunt: ☐ Other: _____

Is chemotherapy access currently in place? Yes: ☐ No: ☐

Are you currently experiencing side effects of chemotherapy? Pain: ☐ Neuropathy: ☐ Nail Fungus: ☐ Constipation: ☐

Other: _____

MRN: _____
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Part B – History of Cancer (continued from page 1)

How are your blood counts? Low: ☐ Normal: ☐ High: ☐

Did you have radiation? Yes: ☐ No: ☐ **Dates of radiation:** _____

Are you currently experiencing side effects of radiation? _____

Are you experiencing pain related to radiation? Yes: ☐ No: ☐

If yes, where is the pain located? _____

Are you experiencing a lack in range of motion? Yes < 50%: ☐ Yes > 50%: ☐ No: ☐

Part C – Surgical History

List All Surgeries No Surgeries: ☐

Surgery 1 *Area of the Body:* _____ *Date* _____
Right: ☐ Left: ☐ Other: _____
Type: Hardware: ☐ Fusion: ☐ Replacement: ☐ Other: _____

Surgery 2 *Area of the Body:* _____ *Date* _____
Right: ☐ Left: ☐ Other: _____
Type: Hardware: ☐ Fusion: ☐ Replacement: ☐ Other: _____

Surgery 3 *Area of the Body:* _____ *Date* _____
Right: ☐ Left: ☐ Other: _____
Type: Hardware: ☐ Fusion: ☐ Replacement: ☐ Other: _____

Surgery 4 *Area of the Body:* _____ *Date* _____
Right: ☐ Left: ☐ Other: _____
Type: Hardware: ☐ Fusion: ☐ Replacement: ☐ Other: _____

Surgery 5 *Area of the Body:* _____ *Date* _____
Right: ☐ Left: ☐ Other: _____
Type: Hardware: ☐ Fusion: ☐ Replacement: ☐ Other: _____

*****Use the back of this intake if you have more surgeries to document**

MRN: _____

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Part D – Goal of Today's Treatment

Did you have a fall or accident in the last year? Yes: ☐ No: ☐ **Describe:** _____

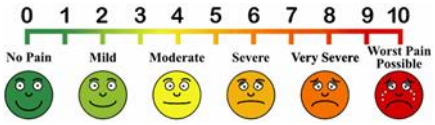
Are there any other health concerns you feel we should be aware of? Yes: ☐ No: ☐

If yes, please explain: _____

Short-term goal of today's massage treatment: _____

Long-term goal of massage treatment: _____

How do you rate your pain level today?
(Circle your pain level on the scale)



Location of pain: _____ **Is range of motion impacted? Describe:** _____

Cause of pain: _____

How do you rate your stress/anxiety level today?
(Circle your stress/anxiety level on the scale)

Cause of stress/anxiety: _____

Patient acknowledgement:

I reviewed this massage intake: Yes: ☐ No: ☐ _____
Patient Initials

I made changes to this massage intake: Yes: ☐ No: ☐ _____
Patient Initials