CONSULTATION FORM
Oncology Massage

Date of consultation: ……..……

PERSONAL DETAILS

Title: …… Name ……..……

Address: ……..……...

..…… Postcode:…….……

No. of Children:…….…...…..……...… Date of Birth: ……..……..……

Profession: ……..……..……... Phone No: …….……..……

E-mail: ……..……..……..…….

Primary care provider, name and address……..

……

CANCER TREATMENT

Type of cancer ……..……..……. Primary □ Metastatic □

Time of diagnosis and recurrences ……

History of treatments: Surgery □ Chemotherapy □ Radiotherapy □ Mistletoe □

Other ……..

When (past or now) ……..……

……

Treatment plan (if current) ……

……

Legacy of the treatment (lymph node removal, etc.)……..…

……

Bone or vital organ involvement (pain or instability)……..……..……

……

General health at present (DVT, etc) …….

……..……..……

How is your daily life affected ……..

……

Other comment: …….

……

……

Address: 5 Earlspark Crescent, Bieldside, Aberdeen, AB15 9AY
Website: www.ainetherapies.co.uk E-mail: info@ainetherapies.co.uk
Mobile: 07798 557454

CONTRA-INDICATIONS

The treatment might be postponed if there is concern about some of the following issues. The client might be referred to their GP for check up before proceeding with a massage.

□ **Undetected DVT** (unilateral leg pain or tenderness, redness or warmth, swelling, enlargement of superficial veins)

□ **Spinal cord compression** (back or girdle pain, stiffness, leg weakness, bilateral tingling and numbness in feet, loss of urge to defecate, loss of urine retention)

□ **Contraction of MRSA** (red, swollen, tender skin, boils or abscesses (pus filled areas), slow healing or infected wounds, fever, tiredness and headache)

□ **Internal radiotherapy -** using internal implants.

DIET AND HEALTH STYLE

DESCRIBE YOUR DIET (Veg/fruit, dairy produce, sweets, protein cont. food)…….

……

……

……

ALCOHOL: ……units/week

TEA: black: …… green: …… white: …… cups/day

COFFEE: ……...… cups/day

LOW FAT DIET: yes …….. no …….. trying ……..

ORGANIC FOOD ……..……

VEGETARIAN/VEGAN or other ……...……..

INTOLERANCE and ALLERGY ……..……

VITAMIN/MINERAL SUPPLEMENTS ……..…….

SENSITIVITY TO HEAT/COLD……...….

SENSITIVITY TO ESSENTIAL OILS ……..

EXERCISE: ……...……

SMOKING: yes …….. no …….. trying to stop ……..

Other comment: ……..……...

……

Aids or STD: ……...…….

Other complementary therapy:……...

Prescribed medication or homeopathic …….

Other: ……..……

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Client declaration:

I declare that the information I have given is correct and that as far I am aware I can undertake treatment without any adverse effects. I do not suffer any contagious diseases (diarrhoea, vomiting, etc.), which could spread to other clients coming to the clinic and I am not under the influence of recreational drugs or alcohol. I have been fully informed about the treatment and any contra-indications and I am willing to proceed. I understand that any complementary therapy treatment does not substitute medical treatment. I agree that my data can be securely stored by A'INE Complementary Therapies, who will not share data with third parties without prior consent.

It is your responsibility and not that of the therapist to consult your GP or Consultant about receiving Oncology massage.

I……..confirm that I have understood the treatment that I am to received and I am willing to proceed with/without (delete as applicable) confirmation from my own GP or Consultant.

I hereby indemnify A'INE Complementary Therapies and the therapist against any adverse reaction sustained as a result of the treatment.

Client Signature: …… Date: …….....……..

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