



Healing Arts Center

Education, Wellness & Being



Welcome to The Healing Arts Center Clinic:

Thank you for your interest in our clinic that offers massages to individuals who are currently being treated for cancer. We are pleased to offer this service free of charge and our goal is that we can provide some relief during your treatments.

The Healing Arts Center is one of the oldest massage schools in the St. Louis area and has provided quality education to hundreds of massage therapists in the St. Louis and surrounding regions.

We have some paperwork that needs to be completed prior to your first appointment.

Health Provider Form: please have your current doctor fill out this form. We need to have this form before services can be performed.

Client Intake Form: This form is two pages and can take some time to fill out. We are sending this to you prior to your appointment to help alleviate the time in our clinic filling out paperwork.

Prior to your massage, you will be meeting with the student therapist and a supervisor in our clinic to talk about your health. Our supervisors are trained in working with cancer patients and will be asking questions to assure that your massage will be a positive and nurturing experience. Together we will determine the best options for your massage. Please feel free to address any questions or concerns to our clinic supervisors.

Massage appointments will last for 30 – 45 minutes depending on factors that will be determined in the meeting before your massage. We realize that many people may have received or are currently receiving massage. Our therapists will not be performing deep tissue or deep pressure massages.

Please feel free to call if you have any questions about the Student Clinic. When you are calling to make your appointment please specify that you are booking an appointment for the Student Cancer Clinic. Please call the number below to book your appointment.

Thank you.

Terrie Yardley-Nohr
Director of Programming
314-647-8080



Student Clinic Oncologist Form

Please have your health care provider fill out the following information prior to your appointment in the student clinic. In an effort to provide a safe and effective massage therapy session, please provide the following information.

Patient Name:	Date:
Type of Cancer:	Area of Body:
Treating Physician:	Hospital or Clinic:
Physician's Phone:	Hospital

Has the patient's condition been treated surgically? Yes No

If yes, date _____. Location of surgery _____

Were any lymph nodes removed? Yes No

If yes, from what part of the body? _____

Does the patient have lymphedema or is there a risk for lymphedema in any area? Yes No

If yes, where? _____

Is the patient receiving radiation therapy? Yes No

Is the patient receiving chemotherapy? Yes No

If yes, what side-effects does the client have as a result of these treatments?

Do any of the treatments or medications that the patient has received effect his or her ability to receive massage therapy? Yes No

If yes, what are these considerations?

Is the client at risk for blood clots? Yes No

Is there any bone metastasis present? Yes No

If yes, in what part of the body? _____

Are there any special instructions for the massage therapist?

The Healing Arts Center provides free massage therapy services to patients with a cancer diagnosis. The intention of this service is to reduce anxiety, alleviate the sensation of alienation, reduce pain and restore some semblance of quality of life to the patient. The clinic is under the supervision of staff members who are trained in working clients who have been diagnosed with a cancer. Massage sessions are adjusted around the contraindications, needs, symptoms and effects that a client may experience. Your suggestions and approval for massage are an important part of this process for both the patient and our students. If you have any other concerns or suggestions, we welcome your thoughts.

Thank you.

Physicians Signature:	Date:
Printed Name:	



Client Intake Form

Name	Date:
Address:	Home Phone
City, State, Zip	Cell Phone
Emergency Contact	DOB:

Medical Information

Have you ever received a massage before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your goal for your massage today?	
When were you diagnosed with cancer?	Date:
What type of cancer?	Type:
Where is it located?	Location:
Are you currently being treated for cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any treatments you are currently receiving:	Side Effects:
When was your last treatment?	Date:
Current Medications and Side Effects: Medications:	Side Effects:
Has your treatment included the removal of any lymph nodes? If so, please list what area was involved.	<input type="checkbox"/> Yes <input type="checkbox"/> No Area:
Has your treatment included any radiation treatments? If so, please list what area was involved.	<input type="checkbox"/> Yes <input type="checkbox"/> No Area:
Do you have any site, pressure or position restrictions due to: <input type="checkbox"/> Incisions, open wounds or drains <input type="checkbox"/> IV, ports, catheters <input type="checkbox"/> Radiation Sites <input type="checkbox"/> Tumor site <input type="checkbox"/> Skin sensitivities <input type="checkbox"/> Bone or spine metastasis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Areas of infection <input type="checkbox"/> History or risk of lymphedema <input type="checkbox"/> Low platelet count	<input type="checkbox"/> Swelling <input type="checkbox"/> History of blood clots <input type="checkbox"/> Fatigue <input type="checkbox"/> Medical devices <input type="checkbox"/> Areas of pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Fracture history <input type="checkbox"/> Anticoagulants <input type="checkbox"/> Rash or itching <input type="checkbox"/> Surgery sites

Other Medical Conditions

<p>Are you currently experiencing any of the following:</p> <p><input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Pain or tenderness</p> <p><input type="checkbox"/> Numbness of tingling</p>	<p>Location:</p>
<p>Do you any medical conditions associated with the following:</p> <p><input type="checkbox"/> Heart Conditions</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> Back/Spine Problems</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Infections/Contagious Disease</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Kidneys</p> <p><input type="checkbox"/> Liver</p> <p><input type="checkbox"/> Reproduction</p> <p><input type="checkbox"/> Digestive</p> <p><input type="checkbox"/> Joints or Arthritis</p>	<p>Explanation:</p>

Disclosure

<p>I have disclosed all known medical conditions and medications that I am aware of at this time. I understand that I will be receiving a massage from a student or graduate of The Healing Arts Center. I understand that I am responsible for informing the therapists of any changes in my medical conditions. I will also inform the therapist of any issues during the massage such as comfort, pain or pressure. The therapists will not diagnose or medically treat during their session.</p>	
<p>Client Signature _____</p> <p>Print Name _____</p>	<p>Date _____</p>
<p>Supervisor Signature _____</p>	
<p>Date _____</p>	