Consent/Intake Form

Name:_____**Date:**_____

Address: _____**City**_____**Zip:**_____

Email address: _____**Date of Birth**_____/_____/_____

Phone: (_____**)** _____-_____ **Referred by:** _____

Emergency Contact name _____**Phone: (**_____**)** _____

Doctor's Name _____ **Phone: (**_____**)** _____

SKIN:
Are you experiencing any skin issues? _____YES _____NO If yes, explain_____
_____
_____

SCALP:
Are you experiencing any scalp issues? _____YES _____ NO If yes, explain_____
_____
____ _____
Are you experiencing any hair loss? _____YES _____ NO Do you wear a wig? YES _____ NO _____

NAILS:
Are you experiencing any nail (finger or toe) issues? _____YES _____NO If yes, explain
_____
_____

MEDICATIONS:
*Chemotherapy? _____YES ____NO Date started Chemo
_____
Name of Chemo drug/s
_____
_____
_____

BLOOD THINNERS:
* Anti-coagulants _____YES _____NO * Steroids? _____YES _____NO

* Any other Medications or Supplements (including Aspirin, vitamins:
_____
_____-__
_____
_____

LIST CURRENT SKIN CARE PRODUCTS THAT YOU USE:

_____
_____
_____
_____
_____

PLEASE ANSWER THE FOLLOWING:

* Type of Cancer _____
  Date Diagnosed_____

* _____YES _____NO **Surgery.** If yes, date/s

_____

* _____YES _____NO **Incision.** If yes, site/location

_____

* _____YES _____NO **Port, PICC, or Central Line**. If yes, location

_____

* _____YES _____NO **Radiation Therapy**. If yes, dates of last treatment

_____

* _____YES _____NO **Lymph Nodes removed**. If yes, # of Lymph Nodes removed

_____

* _____YES _____NO **Lymphedema.** If yes, location/side:

_____

* _____YES _____NO **Swelling or Inflammation**. If yes, location:

_____

* _____YES _____NO **Radiation Burns**. If yes, location:

_____

* _____YES _____NO **Pain or burning**. If yes, location:

_____

* _____YES _____NO **Poor wound healing**. If yes, explain:

_____

* _____YES _____NO **Keloid Scars.** If yes, explain:

_____

* _____YES _____NO **Hypersensitivity or Irritation.** If yes, explain:

_____

* _____YES _____NO **Dryness.** If yes, explain:

_____

* _____YES _____NO **Rashes.** If yes, explain:

_____

*_____YES _____NO **Skin Discoloration.** If yes, explain:

_____

* _____YES _____NO **Peripheral Neuropathy.** If yes, explain:

_____

* _____YES _____NO **Hand/Foot Syndrome (PPE).** If yes, explain: _____

*_____YES _____ NO **Fatigue .** If yes, explain: _____

*_____YES _____ NO **Shortness of breath.** If yes, explain: _____

*_____YES _____ _NO **Chills or Loss of balance**. If yes, explain: _____

*_____YES _____ NO **Physical Impairments**. If yes, describe: _____

*_____YES_____ NO **Claustrophobia.** If yes**,** explain**:** _____

OTHER:

***** Has cancer or cancer treatment affected any of the following functions in your body?
Lungs? _____YES_____NO **Liver? _____**YES_____NO **Nervous System? _____**YES_____NO

Heart? _____YES_____NO **Kidney? _____**YES_____NO **Energy Level? _____**YES_____NO

Immune System? _____YES_____NO **Low Blood Counts? ____**YES_____NO
If YES list current Blood counts
_____
_____

ALLERGIES:
Please list all known allergies (food, drugs, etc).
_____
_____
_____
_____

* Is there any other information you would like your technician to know before starting your Therapy?
____YES ____NO If YES, explain_____
_____
_____

* I acknowledge that all the information provided by me is true and correct to the best of my knowledge and that I **must wait 48 hrs after a Chemotherapy infusion** prior to having a Skin Care Therapy.

I also understand that due to my medical history, cancer therapy and medications, that some skin conditions may re-quire more than one treatment to achieve the desired results.
I understand that in order to achieve certain results, I will need to discontinue the use of home care products containing ingredients that are too strong, aggressive or drying at this time.
(These will be discussed with you by your technician).

Signature _____ Date: ____/____/____

Staff Signature _____ Date: ____/____/____

Staff Comments/Notes:
_____
_____
_____
_____
_____
_____
_____
_____
_____