

Breast Massage Intake

Breast History Please complete if interested in breast massage. All information is kept confidential.

Name	Date
Do you ever experience breast pain or discomfort? Please describe:	YES / NO
Have you ever been diagnosed w/ lumps, cysts, fibrocystic, or dense breasts?	YES / NO
Do you massage your breasts?	YES / NO
Have you had professional breast massage or lymphatic drainage?	YES / NO
Are you interested in receiving breast massage?	YES / NO
Would you be interested in learning breast self massage? (this can be performed over clothes)	YES / NO
Are you interested in education to perform a thorough breast self check?	YES / NO
Do you perform breast self exams?	YES / NO
When were your breasts last examined by a physician?	
When was your last mammogram? (or ultrasound, MRI, thermogram)	
Any history for cancer investigation or treatment (biopsies, lymph nodes removed or radiation therapy)?	YES / NO
Have you ever had breast surgery? What type? (lumpectomy, mastectomy, biopsy, reconstruction, augmentation) Which breast? (right, left, both)	YES / NO
Do you have breast implants? What type? (saline, silicone, flap, other)	YES / NO
Do you wear a bra? If so, how often or how many hours a day?	YES / NO
Do you have deep marks on your skin after you remove your bra?	YES / NO
Have you ever been measured for your best bra size? What is your bra size?	YES / NO
Have you ever had an injury to your breasts or chest area? What was the injury?	YES / NO
Are you currently breast feeding?	YES / NO

PLEASE NOTE: Breast massage and lymphatic mapping/drainage is NOT diagnostic and does NOT replace a breast exam performed by a physician

Acknowledgement and Consent for Massage

I understand that the massage therapist will assess my tissues, but does not diagnose illness, disease, or any other physical disorder. As such, the massage therapist does not prescribe or perform medical treatment, nor spinal manipulation. It has been made clear to me that massage does not substitute for medical examination or treatment. I understand my responsibility to report changes in my health and to give feedback during treatment so the practitioner and I can work together as a team to optimize my experience. **If I feel uncomfortable for any reason during the session, I am at my liberty to pause or discontinue the treatment at any time.** Please initial below to customize your session.

I am happy to work at your comfort level of undressing. We can easily work together through clothing (except shoes and belts). Would you feel most comfortable receiving touch:

_____ over clothes	_____ through a sheet	_____ on skin
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Gluteus, sacrum, and coccyx massage: Treatment to the buttocks and tailbone may be beneficial to reduce pain radiating down the leg, back and pelvic pain, as well as improve posture and ease walking.

_____ I consent to have this area treated	_____ I consent to have this area undraped
_____ I prefer NOT to have this area touched	_____ I consent to treatment over clothes/drape

Pelvic and abdominal massage: Treatment to the abdomen, including the lower stomach below the navel and above the pubic bone, as well as the adductor attachments at the groin and pubic bone, may be beneficial to reduce pain, improve respiration, increase flow of blood and lymph fluid throughout the organ tissue as well as relax the fascia and improve posture. **PLEASE NOTE: The genitals will always remain draped during treatment and are NOT massaged.**

_____ I consent to have this area treated	_____ I consent to have this area undraped
_____ I prefer NOT to have this area touched	_____ I consent to treatment over clothes/drape

Rib and pectoral massage: Treatment to the breast bone and underarms, as well as the upper and lower chest immediately above and below the breast tissue, may be beneficial to reduce pain, improve respiration, increase flow of blood and lymph fluid throughout the organ tissue as well as relax the fascia and improve posture. There may be incidental contact with the breast tissue during this treatment.

_____ I consent to have this area treated	_____ I consent to have this area undraped
_____ I prefer NOT to have this area touched	_____ I consent to treatment over clothes/drape

Breast massage: Treatment of the breasts is performed to increase breast health awareness, relieve congestion and edema in the upper chest and breast tissue, ease tightness due to scar formation from surgery, increase range of motion, move the lymph, prevent stagnation of fluid, alleviate breast symptoms of PMS, enhance milk flow and production for breast feeding, ease discomforts of pregnancy and breastfeeding, reduce breast pain, improve respiration, increase flow of blood and lymph fluid throughout the breast tissue as well as relax the fascia. There may be incidental contact with the nipples during this treatment. If you prefer, you have the option of having a chaperone that you provide in the room during this treatment. **Both men and women have breast tissue, and under current regulations, must consent if massage to this area is to be perform**

_____ I consent to have this area treated	_____ I consent to have this area undraped
_____ I prefer NOT to have this area touched	_____ I consent to treatment over clothes/drape

_____ For comfort reasons, I consent to have this area undraped for the entire treatment (male or female)

Breast massage that includes the nipples and areolas: Treatment of nipples may be beneficial to relieve congestion and edema in the upper chest and breast tissue, increase nipple health awareness, ease tightness due to scar formation from surgery, reduce breast pain, increase flow of blood and lymph fluid throughout the breast tissue as well as relax the fascia. **Both men and women have nipples and areolas, and under current regulations, must consent if massage to this area is to be performed.**

_____ I consent to have this area treated	_____ I consent to have this area undraped
_____ I prefer NOT to have this area touched	_____ I consent to treatment over clothes/drape