Your opinion about Integrative Medicine Services is very important to us.

While not required, we would appreciate your assistance in completing this survey as your answers will help us provide the best service possible with the utmost in caring.

Date: _____ Treatment center: _____ Therapist, Oncology Massage: _____

How many infusion center / day hospital treatments have you received so far? _____

1. Have you ever had a massage? ❑ Yes ❑ No

2. Have you had a massage in the hospital before? ❑ Yes ❑ No If yes, how many? _____

3. Would you like to receive massage during your next infusion center treatment? ❑ Yes ❑ No ❑ Maybe

4. What benefit did you receive from your massage today? **Please mark all that apply.**
   ❑ Pain relief ❑ Reduce neuropathy ❑ Moisturize skin
   ❑ Relaxation ❑ Reduce nausea ❑ Reduce anxiety
   ❑ Feels good ❑ Other _____

Please tell us about yourself - for classification purposes only;

5. What is your age? ❑ 17 or younger ❑ 18-39 ❑ 40-64 ❑ 65+

6. Gender ❑ Non-binary ❑ Male ❑ Female

7. Ethnicity ❑ Black/African American ❑ Hispanic/Latino ❑ White ❑ Asian ❑ Other _____

8. What is your diagnosis? _____ Date of your diagnosis? _____

Your feedback and comments are appreciated and welcomed. *Use back of this document if more space needed.*

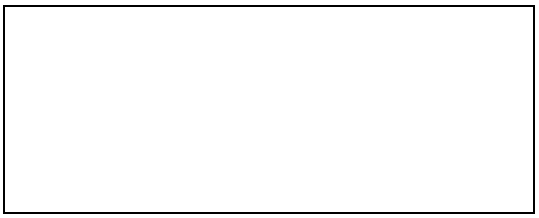
_____

_____

_____

_____

_____



Please return completed
massage feedback form to

Comment Box at
Schedulers' Desk