

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: _____

- 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 _____

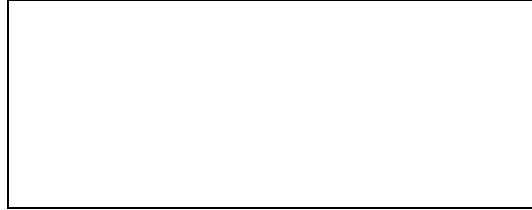
For each of the following statements, indicate how you would rate the massage service by checking the block that best describes your feelings.

- 5. Helpfulness of the massage in reducing physical discomfort Poor Fair Good Very Good Excellent
- 6. Helpfulness of the massage to promote or provide relaxation Poor Fair Good Very Good Excellent
- 7. Benefit of massage therapy experienced today Poor Fair Good Very Good Excellent

Please tell us about yourself (for classification purposes only)

- 10. What is your age? 17 or younger 18-39 40-64 65+
- 11. Gender Non-binary Male Female
- 12. Ethnicity Black/African American Hispanic/Latino White Asian Other _____
- 13. 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
message feedback form to

Comment Box at
Schedulers' Desk