ONCOLOGY MASSAGE INTAKE FORM

Name: _____ Date: _____

Phone Number: _____ Email Address: _____

Occupation: _____ Date of Birth: _____

Address: _____ City/Sate/Zip: _____

Emergency Contact:

Relation: _____ Phone: _____

How did you hear about us? _____

Have you had a massage before? (Yes/No) _____

If yes, was there anything you liked or didn't like? _____

_____

What kind of activities are you able to participate in? _____

_____

Please give us a general idea of your current day-to-day or week-to-week activities, if any:

_____

_____

When were you first diagnosed with cancer? _____

What type of cancer? _____

Is the cancer currently active? _____

Where was/is it located? _____

Are you being treated now? **YES NO** If no, what was the date of your last treatment? _____

What treatments have you undergone & when? ***Please list dates and types of surgery and other treatments:***

_____

_____

_____

_____

Current Medications (for cancer or other condition) not described above: _____

_____

_____

Did your treatment include any removal or radiation of lymph nodes? If yes, please describe where:

_____

_____

Did your treatment include radiation therapy? If yes, please describe where: _____

_____

_____

Do you have any ***site restrictions*** due to:

___ incisions, open wounds, drains or dressings ___ skin sensitivity, rash or skin condition

___ IV, port, ostomy, catheter, or other device (circle) ___ a tumor site ___ radiation site

___ neuropathy ___ bone or spine metastasis ___ fracture history ___ area of infection

___ history/risk of blood clot ___ other (***please specify below***): _____

_____

Do you have any **pressure restrictions** due to:

___ history or risk of lymphedema (**circle which**)

___ anticoagulants ___ bone or spine metastasis ___ fragile / sensitive skin

___ area of pain or burning ___ recent surgery ___ low platelet count ___ steroid med

___ fragile veins ___ fatigue ___ infection or fever ___ other (**please specify below**)

_____

Do you have any ***position restrictions*** due to:

___ incision ___ medication ___ ostomy ___ tumor site ___ difficulty breathing

___ tender skin ___ swelling or risk of swelling (any body area needs elevating?) ***please describe***

_____

___ medical devices ***please describe*** _____

_____

___ discomfort ***please describe*** _____

_____

Has cancer or cancer treatment affected any of the following functions in your body? (***circle current issues)***

___ Lungs ___ Liver ___ Nervous System ___ Heart ___ Kidney ___ Blood counts ___ Energy level

Describe _____

_____

General Signs and Symptoms (check "YES" and add comments if you have or have had any of the following):

Signs/Symptoms	Yes	No	Comments
Any **swelling** or **tendency to swell** anywhere in your body?			
Any sites of **pain** or **tenderness** anywhere in your body?			
Any sites of **numbness** or **reduced sensation** anywhere in your body?			
Any areas of **inflammation**?			

Other Medical Conditions (check "YES" and add comments if you have or have had any of the following):

Medical Conditions	Yes	No	Comments
Skin conditions (rashes, infections, itching)			
Known **allergies** or **sensitivities** (bring any MD-approved or well-tolerated lotion to use)			
Cardiovascular conditions (history of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)			
Liver or **Kidney conditions** (for ex. Kidney failure, hepatitis, portal hypertension, etc.)			
Respiratory or Lung conditions			
Diabetes (describe type, any med, whether blood sugar is well-controlled, any complications)			
Injuries (back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures)			
Arthritis or **Joint problems**			
Digestive problems			
Surgery			