ONCOLOGY MASSAGE QUESTIONNAIRE

General:

Have you had massage before?

If yes, since your diagnosis?

If yes, describe:

- What did you like or dislike about it? - How did it affect you?

Activity & Energy:

What is your activity level?

What is your activity tolerance?

What is your energy level? Good/bad times of day/week? Explain

Any medical restrictions on activities?

Cancer Status:

What type of cancer is (or was) it?

Is the cancer active?

Where is it in your body?

Is it isolated to one area or more than one?

Any bone involvement? Any cancer in your bones or spine?

If so, where?

Does your doctor specify any activity restrictions because of bone involvement?

Are your health care providers (doctors, nurses, PTs, OTs, etc) concerned about the stability of your bones?

- If yes, please explain:

Diagnostic Test(s):

Any recent or scheduled diagnostic tests?

What is (was) the purpose of the test? What were the findings, if any?

Vital Organ:

Is there vital organ involvement - any cancer present in your lungs, liver, kidneys, brain, or heart?

Has cancer or cancer treatment affected the function of any vital organs (lungs, liver, kidneys, brain or heart)?

Pain / Neurological / Movement:

Are you experiencing any pain right now? Where?

Is it new or unfamiliar or increasing?

Have you reported this to your doctor? - What does he/she say about it?

- What is the diagnosis?

Rate your pain level: 0 – 10 (10 is the worse imaginable, 0 is none)

- Does it feel “nervy”?

- Numbness, tingling

- Sharp, shooting, radiating - Burning

- Other strange sensation

Are you experiencing any weakness or problems with movement?

DVT Symptoms:

Experiencing any of these symptoms?

- Pain, tenderness, worsen with standing, walking, swelling? - Any fever?

- When did you notice the onset of the symptoms?

- Has it happened before?

- If yes, does it come and go? - Is it explainable?

- Does your doctor know about it? - What do they say?

- Do you have any history of vascular problems (such as blood clots)? - Do you have any DVT risk factors?

Lymph Node / Lymphedema:

Did you have any lymph node(s) removed? If so where?

If not why wasn't it necessary?

We're any removed that were "negative"?

Have you had any radiation therapy? Where?

Do you have any swelling or tendency to swell?

Any puffiness anywhere?

Do you have any lymphedema history?

Did your doctor or nurse talk with you about lymphedema risk?

Did they urge you to not get your blood pressure taken in certain places or to avoid needle sticks?

Are there any position recommendations or restrictions?

Medications:

List the medications you are currently on and the purpose of each medication

Is it effective?

How does it affect you (any side effects)?

Do you have any transdermal patch? If so, where?

Are the medications injected? If so where?

When was the last injection?

Procedure(s):

Any procedures recently? If so, please list below:

What was the purpose of the procedure?

Is/was it effective?

How did/does it affect you (any side effects/complications)?

Surgery:

When was the surgery?

What was it for?

Was it effective?

How has your body recovered....

- from surgery, anesthesia, incision, side effects?

- any late or lingering effects of surgery long ago?

Is/was there any pain from the surgery? - Where?

Is/was there any loss of sensation or function? - Where?

What is your activity level since the surgery?

Are there any medical restrictions on your activities?

Are you taking any medications related to the surgery? - If so, please list

Chemotherapy:

When do you have your treatment and how often?

What is your schedule of cycles of treatment?

How does it affect you?

Date of most recent treatment - Where are yo in your cycle?

What has your energy level been like?

What has your activity and movement level, day to day and week to week?

How well do you tolerate activity?

How are your blood counts?

Do you remember your numbers?

Are there any effects on your platelets/blood clotting? - Do you have any bruising or bleeding?

Any effects on your white blood cell counts or your immunity? - Are you vulnerable to infection?

Are your red cells affected?

Any anemia as a result of chemo or anything else?

How concerned is your doctor or nurse about your blood counts?

Any restrictions on activity or precautions advised to take?

How has chemotherapy affected your GI tract (gastrointestinal tract), if at all? - In what ways?

How has chemotherapy affected your skin?

Any effects on your hands and feet?

- Neuropathy?

- Skin of hands and/or feet?

- Any redness, tightness, tingling, pain, numbness, skin thickening?

- Any chapping, craning, peeling, blisters ulcers, pain, loss of fingernails or toenails?

- If so, where?

- Are you taking any medications for these symptoms? - If so, list the medicines and what they are for below:

Did your doctor or nurse mention concern about possible effects on the skin of your hands or feet?

What did they say?

Any effects on other neurologic functions or processes like brain fog, trouble with memory, etc?

If you are experiencing hair loss, would you like me to include your head/scalp in the massage? If so, how would you like me to massage it?

Do you have a port or other medical device (i.e. catheter, drains, or ostomy)? - If so, where?

How do you take care of it when you move or lie down? Any effect on comfortable positioning?

Any tubing?

Are there any lingering effects on chemotherapy?

Radiation Therapy:

Are you/have you received radiation therapy?

- If so, was it internal or external? Where?

When?

How did it affect you?

Were there any skin markings (ex. Tattoos)? Describe the entry and exit points

Are there any lingering effects?

Anything else?

Are there any symptoms or side effects you would like addressed? What are your goals for the massage?

How would you like to feel after the massage?

Anything else you want me to know about?

Any massage preferences?

Are there any other health conditions? - If so, please list: