

ONCOLOGY MASSAGE INTAKE FORM

Name: _____ DOB: ___/___/___
Address: _____

Email: _____ Phone: _____ (cell) _____

1. Have you had Massage Therapy before? Yes ___ No ___ If yes, was there anything that you liked or didn't like? _____
2. What kind of activities/exercise do you do? _____
3. When were you first diagnosed with cancer? ___ What type of cancer? _____
Where was/is it located? _____
4. Are you being treated now? Yes ___ No ___
If no, what was the date of your last treatment? ___/___/___ (If you are currently in treatment, or, if your last treatment session was less than 12 months ago, please have your physician complete the accompanying *permission* form.)
5. What treatments have you undergone? Please supply details and types of cancer treatments.

Current cancer medications not described above: _____
6. Current medications for any other condition: _____
7. Did your treatment include any removal or radiation of lymph nodes? Yes ___ No ___
If yes, please describe where: _____
8. Did your treatment include radiation therapy? Yes ___ No ___
If yes, please describe the areas of your body that were affected. _____

9. Do you have any position restrictions? Yes ___ No ___
If yes, please describe where: _____
10. Has cancer/cancer treatment affected any of the following functions in your body?
___heart ___kidney ___blood counts ___energy level ___lungs ___liver ___nervous system

11. Do you have any site restrictions due to:

<input type="checkbox"/> incisions, open wound, drains or dressings	<input type="checkbox"/> IV, port, ostomy, catheter
<input type="checkbox"/> skin sensitivity, rash or skin condition	<input type="checkbox"/> a tumor site
<input type="checkbox"/> bone/spine metastasis	<input type="checkbox"/> radiation site
<input type="checkbox"/> history/risk of blood clots or phlebitis	<input type="checkbox"/> neuropathy
<input type="checkbox"/> infected area	<input type="checkbox"/> fracture history
<input type="checkbox"/> other: _____	

12. Do you have any pressure restrictions due to:

<input type="checkbox"/> history of lymphedema	<input type="checkbox"/> fatigue	<input type="checkbox"/> low platelet count
<input type="checkbox"/> anticoagulants	<input type="checkbox"/> steroid meds	<input type="checkbox"/> fragile/sensitive skin
<input type="checkbox"/> bone/spine metastasis	<input type="checkbox"/> fragile veins	<input type="checkbox"/> fever/infection
<input type="checkbox"/> area of pain/burning	<input type="checkbox"/> recent surgery	
<input type="checkbox"/> other: _____		

General Signs and Symptoms:	YES	NO	Comments
13. Any swelling or tendency to swell anywhere in your body?			
14. Any sites of pain/tenderness anywhere in your body?			
15. Any sites of numbness or reduced sensation in your body?			
16. Any areas of inflammation?			
Other Medical conditions:	YES	NO	Comments
17. Skin conditions (rash/itching)			
18. Allergies or sensitivities			
19. Cardiovascular concerns (such as blood clots, etc)			
20. Liver/kidney conditions			
21. Respiratory or lung conditions			
22. Diabetes			
23. Injuries			
24. Arthritis or joint problems			
25. Gastrointestinal problems			

26. Surgery			

It is my choice to receive massage therapy. I realize the treatment being given is for the purpose of stress reduction, relief from muscle tension, spasm or pain, or for improving circulation. I have stated all medical conditions and medications.

Signature: _____ Date: ____/____/____