Oncology Client Intake Form

Your name: ___________________________________ Date_____________

Telephone # (day) ___-___-____ (eve)___-___-____ (cell)___-___-____

Date of Birth:__/__/____ Email: _______________________

1. Have you had Massage Therapy before? Yes/No If yes, was there anything that you liked or didn't like?

2. 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?

   NOTE- if you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of the massage session, please have your physician complete the MD permission form.

5. What treatments have you undergone? when?
   Please supply dates and types of surgery and other treatments.

6. Current medications, not described above:

Medications	For What Condition?	Effective?	Side- effects?

7. Did your treatment include any removal or radiation of lymph nodes? (If yes, please Describe where).

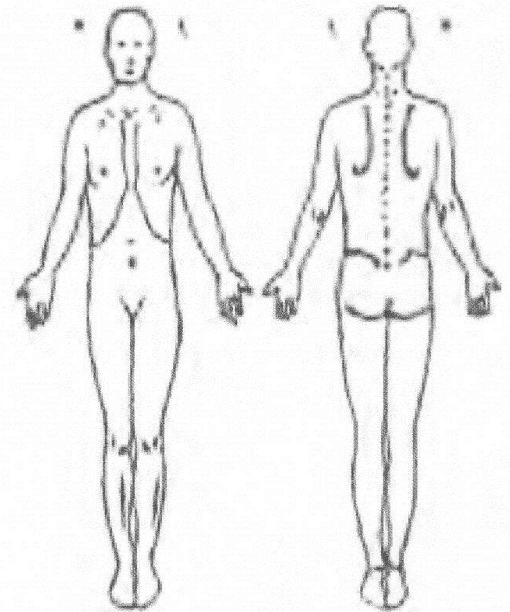
8. Did your treatment include radiation therapy? (If yes, please describe where).

9. 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)

10. Do you have any pressure restrictions due to: history or risk of lymphedema (circle which)

a tumor site	Radiation site	anticoagulants	low platelet count
bone or spine metastasis	neuropathy	bone or sine metastasis	steroid medication
fracture history	area of infection	fragile/sensitive skin	fragile veins
History or risk of blood clots or phlebitis		Area of pain or burning	Fatigue
Other (please describe below)		Recent surgery	Infection or fever
		Other (please describe below	

Circle areas you would like massage to address



How would you describe your stress level?

0 1 2 3 4 5 6 7 8 9 10

No Stress Worst stress imaginable

How would you describe your pain level?

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain imaginable

____

INTAKE FORM

Your Name Again: _______________________________________

11. Do you have any *position restrictions*

incision medication ostomy tumor site difficulty breathing

swelling or risk of swelling (any body area need elevating?) *please describe*

medical devices *please describe*

discomfort *please describe*

12. Has cancer or cancer treatment affected any of the following functions in your body?

Lungs Liver Nervous system Heart Kidney Blood counts Energy Level

Circle any that you are currently experiencing and describe.

General Signs and *Symptoms* Check "yes' and add comments if you have or have had any of the following:

13. Any swelling or tendency to swell anywhere in your body?	Yes	No	Comments
14. Any sites of pain or tenderness anywhere in your body?			
15. Any sites of numbness or reduced sensation anywhere in your body?			

Other Conditions	yes	No
17. Skin conditions (rashes infections, itching)		
18. Known allergies or sensitivities (if you use any physician approved lotion on your skin, please bring it for the massage therapist to use)		
19. conditions (history of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots).		
20. or kidney (for example: kidney failure, hepatitis, portal hypertension. etc.)		
21. Respiratory or conditions		
22. Diabetes (describe type, any medication, whether blood sugar is well controlled, any complications).		
23. Injuries (any back problems, knee problems, tendonitis, Disc injuries, neck problems, recent fractures).		
24. or joint problems		
25. Digestive problems		
26. Surgery		

Is there anything else you would like to tell your massage therapist?

Client Signature:___________________________________ Date: __________________

Massage Therapist Signature:_______________________ Date: __________________