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 or chemotherapy? 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

Do you have any site restrictions due to:

___skin sensitivity, rash, or skin condition	___a tumor site
___bone/spine metastasis	___radiation site
___history/risk of blood clots or phlebitis	___neuropathy
___infected area	___fracture history

12. Do you have any pressure restrictions due to:

___history of lymphedema ___fatigue ___low platelet count
___anticoagulants ___steroid meds ___fragile/sensitive skin
___bone/spine metastasis ___fragile veins ___fever/infection
___area of pain/burning ___recent surgery
___other: ____

General Signs and symptoms:	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 state all medical conditions and medications.

Signature: ___________________________________ Date: _______/_______/_____
Therapist Signature: ____________________________ Date: _______/_______/_____