Oncology Massage Intake Form

Name _____ Date of Birth _____

Address _____ Telephone # (H)_____ (C)_____

Contact Person _____ Telephone # _____

Reason for visit today? _____

Name of Physician _____ Telephone # _____
(If you have just been diagnosed, are currently in treatment, between treatments, or if you have not been in remission for longer than a year, please have your physician complete our permission form)

1. **Have you ever had a massage before? Y N**
2. **When were you first diagnosed with cancer? _____**
3. **What type of cancer have you been diagnosed with? _____**
4. **Where is your original tumor site? _____**
5. **Has your cancer metastasized? Y N If yes, to where? _____**
6. **Is your cancer currently active, or are you in remission? Active Remission**
7. **Complete or Partial Remission? How long?_____**
8. **What treatments have you undergone, and when?**
   Radiation: External or Internal Date of Last treatment _____ Skin markings _____
   _____ Location of Entry & Exit points for the beam _____
   Chemotherapy: When _____ Chemo Drugs _____
   _____(use back of form if necessary)
   Surgery _____
9. **Any lymph nodes removed, injured or radiated? Y N**
   If so, where? _____
10. **Current medications (all) *Continue on back of form if more room needed**
    Name _____to treat_____
    Name _____to treat_____
    Name _____to treat_____
    Name _____to treat_____
11. **Would you like me to include your head/scalp in massage? Y N**
12. **Are there any areas of your body cannot be touched or would be painful if touched?**
    If so, where? _____
13. **Are you able to lay on your back, stomach and sides? Y N**
    Would you like gentle cushioning or support? Y N If yes, where? _____
14. **Has your cancer or its treatment affected any of the following: (circle) lungs, liver, nervous system, heart, kidneys, blood counts, energy level**
15. **Have you had, or do you have any risk of blood clot? Y N**
    If yes, please explain _____
16. **Do you have or have you ever had swelling or lymphedema? Y N**
    If yes, when, where and how long? _____

17. **Allergies:** _____
18. **Activity level:** _____
19. **Are you experiencing: depression anxiety insomnia confusion**
20. **How are you feeling today?** _____
    _____
21. **Are you experiencing any pain, physically or emotionally, right now? Y N**
    If yes, please explain _____
    _____
22. **To your knowledge, do you have/had: low platelet count skin changes constipation low white blood cell count bone pain blood clot infection unexplained pain digestive problems fever neuropathy tiredness easily bruised**
23. **Do you have any medical devices? Y N**
    If yes, please explain _____

Client Statement:
To the best of my knowledge, the above information is accurate and complete.

Signed _____**Date** _____

S

O

A

P

Massage Therapist Signature: _____ **Date** _____