restorative
MASSAGE

ONCOLOGY INTAKE FORM

Name _____ Date of Birth _____

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

_____

2. What kind of activities are you able to participate in? _____
Please give us a general idea of your current day-to-day or week-to-week activities, if any.

_____

3. When were you first diagnosed with cancer? _____ What type of cancer? _____

Is cancer currently active? _____ Where was/is it located? _____

4. Are you being treated now? **Yes** **No** If no, what was the date of your last treatment? _____

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

6. Current ***medications*** (for cancer or other condition) not described above:

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)***
_____a tumor site ____ radiation site ____ neuropathy
_____bone or spine metastasis ____ fracture history
_____area of infection ____ history/risk of blood clot
_____other ***(please describe below)***

10. Do you have any ***pressure restrictions*** due to:

____ history or risk of lymphedema ***(circle which)***
____ anticoagulants ____low platelet count
____ bone or spine metastasis____steroid med
____ fragile/sensitive skin ____fragile veins
____ area of pain or burning ____fatigue
____ recent surgery ____infection or fever
____ other ***(please describe below)***

11. Do you have any ***position restrictions*** due to:

_____incision ____ medication ____ostomy ____tumor site ____difficulty breathing ____ tender skin
_____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? ***(circle current issues)***

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

Other Medical Conditions

Check "yes" and comments if you have or have had any of the following:	***Yes***	***No***	***Comments***
17. ***Skin conditions*** *(rashes, infections, itching)*			
18. Known ***allergies*** or ***sensitivities*** *(Bring any MD-approved or well-tolerated lotion to use)*			
19. ***Cardiovascular conditions*** *(History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)*			
20. ***Liver or Kidney conditions*** *(for example: kidney failure, hepatitis, portal hypertension, etc.)*			
21. ***Respiratory or Lung conditions***			
22. ***Diabetes*** *(describe type, any med, whether blood sugar is well-controlled, any complications.)*			
23. ***Injuries*** *(back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures)*			
24. ***Arthritis or Joint problems***			
25. ***Digestive problems***			
26. ***Surgery***			