Oncology Client Intake Form

If you have been treated for cancer in the past 12 months or are currently in treatment for cancer, please fill out this form. Your answers to the questions on this form are essential for a safe, effective massage therapy session. Please take some time to answer in detail.

Full Name: ____ DOB: ____________________________

Address: ____

City: ____ State: _________ Zip: __________________

Phone #: _____________________________Email: ____

Occupation: ____

Emergency Contact: ______________________________________ Phone #: ___________________________

Relationship: ____

Physician: ____ Phone #: ____________________________

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? ___________________

3. 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, 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 detail, with dates and types of cancer treatments.

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6. **Medication**	**For what condition?**	**Effective?**	**Side-effects?**

7. Did your treatment include any removal or radiation of lymph notes? ❑YES ❑NO *(If yes, please describe where)* ______________________________	8. Did your treatment include radiation therapy? ❑YES ❑NO *(If yes, please describe areas of your body affected)* ______________________________
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 ___ bone or spine metastisis ___ neuropathy ___ fracture history ___ area of infection ___ history or risk of blood clots or phlebitis ___ Other ***(please describe)*** ______________________	10. Do you have any pressure restrictions due to: ___ history or risk of lymphedema ***(circle which)*** ___ anticoagulants ___ low platelet count ___ bone or spine metastisis ___ steroid medication ___ fragile/sensitive skin ___ fragile veins ___ area of pain or burning ___ fatigue ___ recent surgery ___ infection or fever ___ Other (please describe) ____________________ ____

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?

___ 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 add comments if you have OR have had any of the following:	**Yes**	**No**	**Comments**
17. ***Skin conditions*** (rashes, infections, itching)			
18. Known ***Allergies*** or ***Sensitivity*** *(if you use any physician-approved lotion on your skin, please bring it for the massage therapist to use)*			
19. ***Cardiovascular conditions*** *(for example: heart condition, high blood pressure, angina, hardening of the arteries, history of stroke, severe 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 medication, whether blood sugar is well-controlled, any complications)*			
23. ***Injuries*** *(any back problems, knee problems, tendonitis, disc injuries, neck problems, recent fractures)*			
24. ***Arthritis*** or ***Joint problems***			
25. ***Gastrointestinal problems***			
26. ***Surgery***			

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

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Client Signature: ____________________________________ Date: ____________________

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