Oncology Client Intake Form

If you have been treated for cancer in the past 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:*_____

*Physian:*_____*Phone#:*_____

1. *Have you had message 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?* _____ *What stage of Cancer?*_____
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 consent form.

5. *What treatments have you undergone? Please supply detail, with dates and types or cancer treatments*
   _____
   _____
   _____

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 metastasis _____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 **(circlewhich)** ____anticoagulants ____low platelet count ____ bone or spine metastasis ____fatigue ____fragile/sensitive skin ____steroid medication ____area of pain or burning ____fragile veins ____recent surgery ____ infection or fever ____Other(please describe**)**_____

11. Do you have any position restrictions due to:

____incision ___medication ____ ostomy ___tumor site ___tender skin ___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 treatments 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)_____

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 sensations 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 hypertensions, ect.)*			
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***			

If there is anything else you would like to tell your massage therapist?_____

_____

_____

_____

_____

_____

_____

Client Signature_____Date:_____

Massage Therapy Acknowledgment/ Consent

for People Living With Cancer

I, _____ (Client/Patient)

Understand that the practice of massage therapy for the person living with cancer is performed for stress reduction and to assist relaxation. I understand that the massage therapist does not diagnose illness, disease, or any other physical disorder. As such, the massage therapist does not prescribe or perform medical treatment nor spinal manipulation. It has been made clear to me that massage therapy does not substitute for medical examination or treatment. Because a massage therapist must be aware of existing physical conditions, I take it upon myself to keep the massage therapist updated on my physical health. I have, to the best of my knowledge, stated all of my known medical information.

By signing this form, the client's attending physician acknowledges receipt of information that the above-mentioned client does intend to receive massage therapy for the above stated purpose and gives consent for their patient to receive massage therapy.

Client and physician agree to inform the massage therapist of any conditions which may be a contraindication for the practice of massage therapy.

Client/Patient_____Date_____

Attending
Physician_____Date_____

Massage
Therapist_____Date_____