



# Oncology Massage Intake Form *(Must accompany a complete health history)*

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

When were you diagnosed? \_\_\_\_\_ Who is your oncologist? \_\_\_\_\_

What type of cancer? \_\_\_\_\_ Date of last visit? \_\_\_\_\_

Where was it located? \_\_\_\_\_ How often do you see your oncologist? \_\_\_\_\_

What is the present status of your cancer? \_\_\_\_\_

**Sugery/Procedure:**    Type \_\_\_\_\_ Date \_\_\_\_\_

Lymph nodes removed:    Number \_\_\_\_\_    Where \_\_\_\_\_

Reconstruction:    Date(s)/Procedure(s) \_\_\_\_\_

Side Effects: \_\_\_\_\_

**Chemotherapy**    No. of Treatments \_\_\_\_\_    Beginning Date \_\_\_\_\_    End Date \_\_\_\_\_

\_\_\_\_\_    No. of Treatments \_\_\_\_\_    Beginning Date \_\_\_\_\_    End Date \_\_\_\_\_

\_\_\_\_\_    No. of Treatments \_\_\_\_\_    Beginning Date \_\_\_\_\_    End Date \_\_\_\_\_

Side Effects: \_\_\_\_\_

**Radiation**    No. of Treatments \_\_\_\_\_    Beginning Date \_\_\_\_\_    End Date \_\_\_\_\_

Area of Treatment \_\_\_\_\_    Nodes Irradiated in the neck, armpit or groin?    Yes    No

\_\_\_\_\_    No. of Treatments \_\_\_\_\_    Beginning Date \_\_\_\_\_    End Date \_\_\_\_\_

Area of Treatment \_\_\_\_\_    Nodes Irradiated in the neck, armpit or groin?    Yes    No

Side Effects: \_\_\_\_\_

**Other**    Please list any other treatment or medications \_\_\_\_\_

Has any doctor said anything to you about lymphedema?    Yes    No    bone metastases?    Yes    No

Medical Devices:    IV Catheter    Port    Breast Expander    Breast Prosthesis    Urinary Catheter  
Ostomy    Feeding Tube (PEG)    Other



# Oncology Massage Intake Form Page 2 of 2 (Must accompany a complete health history)

Name \_\_\_\_\_

**Side Effects**

Check here if explanation(s) below

| <b>GI Conditions</b>                  | Current | Past | <b>Nervous System</b>                                 | Current | Past |
|---------------------------------------|---------|------|---|---------|------|
| nausea                                |         |      | burn/itch/tingle/prickle/numb in arms/hands/legs/feet |         |      |
| vomiting                              |         |      | memory problems                                       |         |      |
| low appetite                          |         |      | <b>Circulatory/Blood</b>                              |         |      |
| mouth sores                           |         |      | edema   |         |      |
| wt. loss                              |         |      | easy bruising   |         |      |
| wt. gain                              |         |      | low platelet  |         |      |
| diarrhea                              |         |      | low white count                                       |         |      |
| constipation                          |         |      | blood clot  |         |      |
| <b>Musculoskeletal</b>                |         |      | excessively cold/warm                                 |         |      |
| Osteoporosis                          |         |      | lymphedema  |         |      |
| bone pain                             |         |      | heart condition                                       |         |      |
| adhesions                             |         |      | high blood pressure                                   |         |      |
| incisions                             |         |      | lung condition  |         |      |
| headache                              |         |      | <b>General</b>  |         |      |
| touch/pressure                        |         |      | fatigue   |         |      |
| sensitivity                           |         |      | depression  |         |      |
| decreased range of motion or function |         |      | anxiety   |         |      |
| pain                                  |         |      | allergies   |         |      |
| former injuries                       |         |      | systemic infection                                    |         |      |
| fractures                             |         |      | infectious condition                                  |         |      |
| joint problems                        |         |      |   |         |      |
| joint replacement                     |         |      |   |         |      |
| <b>Skin</b>                           |         |      | <b>Explanations (as needed)</b>                       |         |      |
| skin infection                        |         |      |   |         |      |
| dry skin                              |         |      |   |         |      |
| fragile skin                          |         |      |   |         |      |
| skin irritation                       |         |      |   |         |      |
| radiation skin reaction               |         |      |   |         |      |
| hair loss                             |         |      |   |         |      |

**Current Medications**

|           |         |              |
|-----------|---------|--------------|
| Drug Name | Purpose | Side Effects |
|-----------|---------|--------------|