

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?

<p>7. Did your treatment include any removal or Radiation of lymph nodes? <input type="checkbox"/> YES <input type="checkbox"/> NO (if yes, please describe where)</p>	<p>8. Did your treatment include radiation therapy? <input type="checkbox"/> YES <input type="checkbox"/> No (If yes, please describe areas of your body affected) _____</p>
<p>9. Do you have any site restrictions due to: <input type="checkbox"/> incisions, open wounds, drains or dressings <input type="checkbox"/> skin sensitivity, rash, or skin condition <input type="checkbox"/> IV, port, ostomy, catheter, or other device (Circle) <input type="checkbox"/> a tumor site <input type="checkbox"/> radiation site <input type="checkbox"/> bone or spine metastasis <input type="checkbox"/> neuropathy <input type="checkbox"/> fracture history <input type="checkbox"/> area of infection <input type="checkbox"/> history or risk of blood clots or phlebitis <input type="checkbox"/> Other (please describe) _____</p>	<p>10. Do you have any pressure restrictions due to: <input type="checkbox"/> history or risk of lymphedema (circle which) <input type="checkbox"/> anticoagulants <input type="checkbox"/> low platelet count <input type="checkbox"/> bone or spine metastasis <input type="checkbox"/> fatigue <input type="checkbox"/> fragile/sensitive skin <input type="checkbox"/> steroid medication <input type="checkbox"/> area of pain or burning <input type="checkbox"/> fragile veins <input type="checkbox"/> recent surgery <input type="checkbox"/> infection or fever <input type="checkbox"/> Other(please describe) _____</p>

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 hypertension, 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 _____