Oncology Massage Intake Form

Name_____Date_____

When were you diagnosed?_____

What type of cancer?_____

Where was it located?_____

What is the present status of your cancer?_____

Who is your oncologist?_____

Date of last visit?_____

How often do you see your oncologist?_____

Surgery/Procedure Type:

_____

_____

Date_____

Lymph nodes removed?_____ Number_____

Where:_____

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

_____

_____

Chemotherapy: Number of Treatments:_____

Beginning Date:_____ End:_____

Chemo Medications:_____

Radiation: Number of Treatments: _____

Beginning Date: _____ End: _____

Area of Treatment _____

Other Treatments/Medications:

_____

_____

Steroids **Blood Thinners** **Antidepressants** **Pain Killers**

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

Bone metastases? **Yes** **No**

Medical Devices: **Central Line** **PICC** **Port**

Breast Expander **Breast Prosthesis**

Urostomy **Colostomy** **Feeding Tube (PEG)**

Other_____

Easy Bruising	**Low White Cell Count**	**Blood Clots**
Low Platelets	**Edema**	**Bone Fragility**
Fragile/Sensitive Skin	**Metastases**	**Neuropathy**
Calf Tenderness	**Radiation Burn**	**Skin Concerns**
Nausea	**Short of Breath**	**Anxiety**
Positional Pain/Discomfort		