Essential Medical Massage

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Oncology Client Intake Form

(This form must accompany a completed Health History Client Intake Form.)

Name: _____ Age: _____ Sex: M/F Date: _____

Type of Cancer, Stage, Location: _____

Date of Diagnosis: _____ Is the cancer currently active? _____

Are you in treatment now? YES/NO If no, when did you finish treatment? _____
* If you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of this massage session, please have your physician complete the MD permission form. See me for the form. Form attached? _____

Oncologist Doctor's Name/Hospital Name: _____
Last visit _____ How often do you see your doctor? _____

Treatment Review

Surgery: YES/NO Describe: _____
Date:
Please check off any side effects that you have experienced from surgery.
Fatigue ___ Nausea and Vomiting ____Emotional Effects _____ Temporary Pain _____
Loss of Appetite _____ Bruising _____Swelling _____ Lymphedema _____
Constipation _____ Diarrhea _____

Chemotherapy: YES/NO Number of Treatments: _____
Dates:
Please check off any side effects that you have experienced from chemotherapy.
Fatigue ___ Nausea and Vomiting ___ Pain ____ Infection ____ Diarrhea _____
Constipation _____ Anemia _____ Muscle/Bone Aches ___ Appetite changes _____
Memory changes _____ Mouth, Gum, Throat Problems ___ Decreased taste ___
Insomnia ___ Emotional Effects ____Weight Loss/Gain _____ Changes in Skin and Nails ____
Alopecia (hair loss) ____Swelling (fluid retention) ____ Neuropathy (hands/feet) _____

Radiation: YES/NO Area/Rounds of Treatments: _____
Dates:
Please check off any side effects that you have experienced from radiation.
Fatigue ___ Nausea ___ Appetite changes _____ Diarrhea _____Constipation _____
Mouth Sores ___ Dry Mouth _____ Muscle/Bone Aches ____ Skin Irritation ____
Poor Skin Healing ____ Decrease taste ____ Insomnia ___ Emotional Effects _____
Weight Loss/Gain _____ Memory Problems ____ Neuropathy (hands/feet) _____

Did your treatment include any removal or radiation of lymph nodes? YES/NO
Which treatment?_____ How many nodes were compromised? _____
Axilla _____ Neck _____ Groin _____

Have you experienced edema or lymphedema? YES/NO
Location: _____ More details: _____

Have you experienced deep vein thrombosis (blood clots)? YES/NO Location: _____
If yes, please explain.

Do you have a recent history of blood clots? YES/NO Location: _____
If yes, please explain.

Has cancer or cancer treatment affected any of the following? (indicate by placing an "x")
_____ Lungs _____ Liver _____ Nervous system _____ Heart _____Kidneys
_____Blood Counts _____ Energy Level _____Bones

Do you know your current blood count? YES/NO If yes, what is it? _____

Current Medications (for cancer or any other condition) and the reasons that you are taking them:

Current Nutritional Supplements and Herbs:

Have you tried any complementary and alternative methods for cancer management? YES/NO If yes, please explain.

Describe your energy level today (1-5, 5 being the highest).

<u>Site Restriction Questions.</u>

Do you have any

_____ incisions, open wounds, drains or dressings
_____ skin sensitivity, rash or skin condition
_____ area of infection _____history/risk of blood clot
_____ a tumor site _____radiation site _____neuropathy
_____ bone or spine metastasis _____ fracture history
_____ IV, port, ostomy, catheter, breast expander/prosthesis
_____ new pain or discomfort
_____ other (please explain)
_____ lymph node removal or radiated
_____ alopecia (hair loss)

<u>Pressure Adjustment Questions.</u>

Please indicate if any of the following apply to you.

_____ history or risk of lymphedema (circle one or both)
_____ lymph node removal/radiated
_____ neuropathy in hands or feet
_____ anticoagulants (blood thinners)
_____ bone or spine metastasis
_____ fragile/sensitive skin
_____ area of pain or burning
_____ recent surgery
_____ easy bruising
_____ low platelets (thrombocytopenia)
_____ steroid medication
_____ fragile veins
_____ fatigue
_____ infection or fever
_____ bone fragility/density loss

Positioning Modification Questions.

When you are on the massage table, should I make any positioning adjustments for you because of

_____ incisions _____medications _____tumor site _____tender skin
_____ breathing difficulty _____ not feeling comfortable with a certain position
_____ swelling or risk of swelling (any body area that needs to be elevated?)
_____ medical devices (please describe) _____
_____ discomfort (please describe) _____

Do you have any of the following? If yes, please explain.

Skin conditions _____

Known allergies _____

Cardiovascular conditions (high/low blood pressure, varicose veins, blood clots, history of heart condition) _____

Liver or Kidney conditions _____

Respiratory or Lung conditions _____

Diabetes _____

Injuries (back, neck, hip or knee) _____

Arthritis or joint problems _____

Digestive problems _____

I understand that the massage I receive is provided for the basic purpose of relaxation. If I experience any pain or discomfort during the session, I will immediately inform the therapist. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to my changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist Date