Oncology Massage Client Intake Form

Personal Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ DOB: _____

Date of birth: _____ Emergency Contact: _____

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? Y N If yes, how often? _____

Do you have difficulty lying on your back, front or side? Y N If yes, please explain _____

_____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Y N If yes, please explain _____

_____

Do you have sensitive skin? Y N

Are you wearing: ☐ contact lenses ☐ dentures ☐ hearing aids ☐ prosthetics

When were you first diagnosed with cancer? _____ What type of cancer? _____

Where was/is it located? _____

Is cancer active? Yes No Are you being treated now? Yes No

If no, what was the date of your last treatment? _____

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

_____

_____

Current medications, not described above: _____

_____

Did your treatment include any removal of lymph nodes? (If yes, please describe where) _____

_____

Did your treatment include radiation therapy? (If yes, please describe where) _____

_____

Has cancer or cancer treatment affected any of the following functions in your body?

_____ Lungs _____ Liver _____ Nervous system _____ Heart _____ Kidney _____ Blood counts

_____ Energy level Please describe: _____

Oncology Massage Client Intake Form Continued

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) _____ bone or spine metastasis

_____ a tumor site _____ radiation site _____ history or risk of blood clots or phlebitis

_____ neuropathy _____ fracture history _____ area of infection _____ other:

Do you have any **pressure restrictions** due to:

_____ history or risk of lymphedema (circle which one) _____ fragile or sensitive skin

_____ anticoagulant _____ bone or spine metastasis _____ low platelet count _____ fatigue

_____ fragile veins _____ steroid medication _____ area of pain or burning

_____ infection or fever _____ recent surgery _____ other: _____

Do you have any **position restrictions** due to:

_____ incision _____ medication _____ ostomy _____ tumor site _____ difficulty breathing

_____ swelling or risk of swelling (any body area need elevating?) Please describe: _____

_____ tender skin _____ medical devices Please describe: _____

_____ discomfort Please describe: _____

General Signs and Symptoms

Check "yes" and add comments if you have Or have had any of the following:	**Yes**	**No**	**Comments**
Any swelling or tendency to swell anywhere in your body?			
Any sites of pain or tenderness anywhere in your body?			
Any sites of numbness or reduced sensation anywhere in your body?			
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**
Skin conditions (rashes, infections, itching)			
Known allergies or sensitivities			
Respiratory or lung conditions			

Oncology Massage Client Intake form Continued

Check "yes" and add comments if you have Or have had any of the following:	Yes	No	Comments
Cardiovascular conditions (for example: heart condition, high blood pressure, angina, hardening of the arteries, history of stroke, sever varicose veins, blood clots)			
Liver or kidney conditions (for example: kidney failure, hepatitis, portal hypertension.)			
Diabetes (type, medication, whether blood sugar is well-controlled, any complications)			
Injuries (any back problems, disc injuries, neck problems, recent fracures)			
Arthritis or joint problems			
Gastrointestinal problems			
Surgery			

Information

How did you hear about me? _____ May I send newsletter/promotional emails? Y N

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. Massage should be modified under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions to the best of my knowledge.
3. Late arrivals – sessions may be shortened in order to accommodate appointments that follow. Payment is expected in full regardless of length of treatment given. Please arrive at least ten minutes before your scheduled appointment time in order to ensure a full massage session.
4. You may cancel your appointment, without charge, any time before the close of business on the business day preceding your appointment. Same day cancellations will be charged 50% of the scheduled service price. If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service.

Signature: _____ Date: _____