Oncology Intake Form

Name_____ Today's Date_____

Address_____ City_____

State_____ Zip code_____

Phone number (_____) _____

Email_____ Date of birth _____

Referred by_____

Emergency Contact_____ Phone number (_____) _____

1. Have you had Massage Therapy before? **Yes / No** If yes, was there anything that you liked or didn't like?

2. How would you like massage to support you?

3. What kind of activities are you able to participate in? _____
   Please give us a general idea of your current day-to-day or week-to-week activities, if any.

4. My primary health care provider is aware that I receive massage? **Yes / No**

5. When were you first diagnosed with cancer?_____

   What type of cancer?_____ Is cancer currently active? **Yes / No**

   Where was / is it located?_____

6. Are you being treated now? **Yes / No**
   If no, when was the last date of treatment?_____

7. What treatments have you had, when?
   (please supply dates and types of surgery and other treatments)

8. Current medications (for cancer or other conditions not described above):

9. Did your treatment include any removal or radiation of lymph nodes? **Yes / No**
If yes, please describe where.

10. Did you treatment include radiation therapy? **Yes / No**
If yes, please describe where.

11. Do you have any **sites** to be mindful due to:
_____ incisions, open wounds, drains, or dressings
_____ skin sensitivity, rash, or skin condition
_____ IV, port, ostomy, catheter, or other device (**Circle)**
_____ a tumor site _____radiation site _____neuropathy
_____ bone or spine metastasis _____ fracture history
_____ area of infection _____ history/risk of blood clot
_____ other **(please describe below)**

12. Are you experiencing any of the following that would effect the massage **pressure:**
_____ history of lymphedema
_____ anticoagulants _____ low platelet count
_____ bone or spine metastasis _____ steroid med
_____ fragile/sensitive skin _____ fragile veins
_____ area of pain or burning _____ fatigue
_____ recent surgery _____ infection or fever
_____ other (please describe below)

13. Do you have any **positional** needs due to:
_____ incisions _____ swelling
_____ medical devices **(please describe)** _____

_____ tumor site _____ difficultly breathing
_____ discomfort **(please describe)** _____