Oncology Massage Intake Form

(Must accompany a complete health history)

Name _____ Today's 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): _____

Side Effects: _____

Chemotherapy: Number of Treatments:_____ Beginning Date:_____ End:_____

Number of Treatments:_____ Beginning Date:_____ End:_____

Number of Treatments:_____ Beginning Date:_____ End:_____

Side Effects: _____

Radiation:

Number of Treatments: _____ Beginning Date: _____ End: _____

Area of Treatment _____ Nodes Irradiated in the neck, armpit, or groin? Yes No

Number of Treatments:_____ Begin Date:_____ End:_____

Area of Treatment _____ Nodes Irradiated in the neck, armpit, or groin? Yes No

Side Effects: _____

Other: Please list any other treatments or medications:

_____

_____

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

Medical Devices: IV catheter port breast expander breast prosthesis

urinary catheter ostomy feeding tube (PEG) Other_____

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Side Effects: (Circle) current conditions. Underline past conditions ❒ Check here if explanation below.

GI Conditions: nausea vomiting low appetite mouth sores wt. loss wt. gain diarrhea constipation

Musculoskeletal: Osteoporosis bone pain adhesions incision headache touch/pressure sensitivity decreased range of motion or function pain former injuries factures joint problems joint replacement

Nervous System: burn/itch/tingle/prickle/numbness in arms,/hands/legs/feet memory problems

Skin: skin infection dry skin fragile skin skin irritation radiation skin reaction hair loss

Circulatory/Blood: edema easy bruising low platelet low white count blood clot excessively cold/warm lymphedema heart condition high blood pressure lung condition

General: fatigue depression anxiety allergies systemic infection infectious condition

Other: current tumor enlarged nodes/spleen/liver radioactivity other_____

Current Medications:

Drug name	Purpose	Side Effects

Explanations: (as needed)