Suburban Soul Massage LLC

Customized Massage Therapy

Oncology Massage Intake Form

Please fill these forms out in addition to the Patient Intake/ Health History form

Name____ Date_____________________

When diagnosed? ____

Type of Cancer____

Where is it located? ____

What is present state of your cancer? Please briefly explain.

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____

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Who is your Oncologists? ____

Date of last visit ____

How often do you see your Oncologists? _______________________________________

Surgery/Procedures

Type of Surgery/Procedures____

Date of Surgury/Procedure____

Lymph nodes Removed: Yes No

If Yes, where were lymph nodes removed _______________________________________

How many lymph nodes removed? ____

Reconstruction Dates and Procedures ____

____

____

Side Effects____

____

____

Chemotherapy

Number of Treatments________ Beginning Date________ End Date ____________

Number of Treatments________ Beginning Date________ End Date ____________

Number of Treatments________ Beginning Date________ End Date ____________

Side effects ____

____

____

Radiation

Number of Treatments________ Beginning Date________ End Date ____________

Area of treatment(please include Right or Left side) ____

____

Nodes irradiated in neck, armpit, or groin? Yes No

Number of Treatments________ Beginning Date________ End Date ____________

Area of treatment (please include Right or Left side) ____

____

Any side effects from Radiation treatment? ____

____

____

Please list any other procedures or medications. ____

____

____

Has your doctor said lymphedema to you? Yes No Bone metastasis? Yes No

Medical Devices

IV Cather Port Breast Expander Breast Prothesis

Feeding Tube(PEG) Urinary Cather Other ________________________

Side Effects Circle Current Conditions Underline Past Conditions

GI Conditions: Nausea Vomiting Low Appetite Mouth sores

Weight loss Weight Gain Diarrhea Constipation

Musculoskeletal: Osteoporosis Bone Pain Adhesions Headaches

Touch/Pressure Sensitivity Decreased Range of Motion or Function

Pain Joint Pain Joint Replacement Fractures Former Injuries

Nervous System: Burning Itching Tingling Numbness in Feet

Burning Itching Tingling Numbness in Arms

Memory Loss Neuropathy in Feet Neuropathy in Hands

Skin: Dry Skin Fragile Skin Skin Infection

Hair Loss Radiation Skin Reaction

Circulatory/Blood: Edema/Swelling Easy Bruising Blood Clots

Low Platelet Count Low White Cell Count Excessively Hot Excessively Cold

Lymphedema Heart Condition High Blood Pressure Low Blood Pressure

General: Anxiety Allergies Depression Fatigue Infectious Conditions

Systemic Infection

Other: Current Tumor Enlarged Lymph Node Enlarged Spleen

Enlarged Liver Radioactivity

Current Medications

Drug Name	Purpose	Side Effects

Explanations as Needed

____
____
____
____
____

I have completed this health form to the best of my knowledge. I understand that massage is to relieve muscular tension and aid in relaxation and does not take the place of a physician's care. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services.

I understand that massage therapy is a health aid and does not take the place of a physicians' care. Any information exchanged during a massage session is confidential and is only used to provide the best massage care. If I am having or develop any complications, I will discuss with my massage therapist. If I feel any discomfort or pain at all during the massage I will inform my massage therapist at once.

I hereby voluntarily release Suburban Soul Massage, LLC and its therapists from any liability should my condition be aggravated at any time. By signing below, I agree that I have read the information above and have decided to receive an oncology massage at my own risk. I affirm that I have stated all know medical conditions and answered all questions honestly. I agree to keep therapist updated on all changes in my medical profile and understand that the therapist and Suburban Soul Massage, LLC will not be held liable for my failure to do so.

Print Your Name____ DATE_____________

Signature____ DATE____________

Therapist Signature____ DATE__________