

## Oncology Massage Intake Form

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

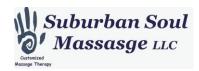
Name	Date
When were diagnosed?	
Type of Cancer	
Where is it located?	
What is present state of your cancer? Please briefly explain.	
Who is your Oncologists?	
Date of last visit	
How often do you see your Oncologists?	
Surgery/Procedures	
Type of Surgery/Procedures	
Date of Surgury/Procedure	
Lymph nodes Removed Yes No	
If Yes, where were lymph nodes removed	



How many lymph nodes rem	noved			
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		
Radiation				
Number of Treatments	Beginning Date	End Date		
	clude Right or Left side)			
	armpit or groin. Yes or No			
Number of Treatments	Beginning Date	End Date		
Area of treatment( please in	clude Right or Left side)			



Nodes irradiated in neck, armpit or groin. Yes or No
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 Tir	ngling Numbness in Arms Memory Loss
Neuropathy in Feet	Neuropathy in Hands
Skin: Dry Skin	Fragile Skin Skin Infection
Hair Loss Rac	diation Skin Reaction
Circulatory/Blood	Edema/Swelling Easy Bruising Blood Clots
Low Platelet Count	Low White Cell Count Excessively Hot Excessively Cold
Lymphedema He	eart Condition High Blood Pressure Low Blood Pressure
<b>General:</b> Anxiety	Allergies Depression Fatigue Infectious Conditions
Systemic Infection	
Other:	
Current Tumor	Enlarged Lymph Node Enlarged Spleen
Enlarged Liver	Radioactivity
<b>Current Medication</b>	<b>IS</b>
Drug Name	Purpose Side Effects

Suburban Soul Massasge LLC Cutomized Massage Therapy			
Explanations as Needed			
relieve muscular tension and a	id in relaxation and does r ring a Massage or Bodywo	rledge. I understand that massage is to not take the place of a physician's cartork session is confidential and is only	e.
care. Any information exchange provide the best massage care	ged during a massage sess . If I am having or develop	es not take the place of a physicians' sion is confidential and is only used to any complications, I will discuss with all during the massage I will inform m	o :h
should my condition be aggravinformation above and have deliberated all know medical	vated at any time. By signiecided to receive an oncolo conditions and answered a es in my medical profile ar	C and its therapists from any liability ing below, I agree that I have read the ogy massage at my own risk. I affirm all questions honestly. I agree to kee not understand that the therapist and my failure to do so.	that
Print Your Name		DATE	
Signature		DATE	
Therapists Signature		DATE	