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 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 _____

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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 or No

Number of Treatments_____ Beginning Date_____ End Date _____

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

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_____

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

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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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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_____ _____ _____

_____ _____ _____

_____ _____ _____

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**_____

Therapists Signature_____ **DATE**_____