Journey Therapeutic Massage

Oncology Massage Intake Form

Name:

Address:

Phone:

Email Address:

Would you like to be on our email mailing list? Please circle one. **Yes** **No**

Date of Birth:

Have you had massage therapy before? **Yes** **No** If yes, was there anything you liked or didn't like?

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.

When were you first diagnosed with cancer?_____Is cancer currently active?_____

What type of cancer?_____Where was/is it located?_____

Are you being treated now? **Yes** **No** If no, what was the date of your last treatment?_____

Note: If you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of the massage session, please have your physician complete the MD permission form.

What treatments have you undergone, when? Please list dates and types of surgery and other treatments.

Current ***medications*** (for cancer or other condition) not described above:

Did your treatment include any removal or radiation of lymph nodes? ***If yes, please describe where.***

Did your treatment include radiation therapy***? If yes, please describe where:***

Do you have any ***site restrictions*** 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)***

Do you have any ***pressure restrictions*** due to: _____history or risk or lymphedema (circle which)
_____anticoagulants _____low platelet _____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)***

Do you have any ***position restrictions*** due to: _____incision _____medication _____ostomy
_____tumor site _____difficulty breathing _____tender skin _____swelling or risk of swelling (any body area need elevating?) ***please describe***

_____medical devices ***please describe***

_____discomfort ***please describe***

Has cancer or cancer treatment affected any of the following functions in your body? (***circle current issues)*** _____Lungs _____Liver _____Nervous System _____Heart _____Kidney
_____Blood Counts _____Energy Level
(Circle any that you are currently experiencing and describe)

General Signs and Symptoms

Check "yes" and add comments if you have or have had any of the following:	***Yes***	***No***	***Comments***
Any ***swelling*** or ***tendency to swell*** anywhere in your body			
Any sites of ***pain*** or ***tenderness*** anywhere in your body			
Any sites of ***numbness*** or ***reduced sensation*** anywhere in your body			
Any areas of ***inflammation***			

Other Medical Conditions

Check "yes" and add comments if you have or have had any of the following:	***Yes***	***No***	***Comments***
Skin conditions (rashes, infections, itching)			
Respiratory or Lung conditions			

Cardiovascular conditions (History or heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)			
Liver or Kidney conditions (for example: kidney failure, hepatitis, portal hypertension, etc.			
Known ***allergies or sensitivities*** (if you use any physician-approved or well-tolerated lotion on your skin, please bring it for us to use with you)			
Diabetes (describe type, any medication, whether blood sugar is well-controlled, any complications)			
Injuries (any back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures)			
Arthritis or Joint problems			
Digestive problems			
Surgery			