Oncology Massage Intake Form

Name: ________________________________ DOB/Age: ______________ Date: _________

Address: ____

Email: _______________________________________Phone: ___________________________

Type of Cancer, Stage, Location: ____

Date of Diagnosis: _______________________ Is the cancer currently active? _________

Are you in treatment now? YES/NO If no, when did you finish treatment? _________

Oncologist Doctor's Name/Hospital Name: ______________________________________

Last visit __________________ How often do you see your doctor? _________________

Treatment Review

Surgery: YES/NO Describe: ____
Date:

Side effects: Fatigue _______ Nausea or Vomiting _______ Temporary Pain _________
Appetite changes ________ Bruising or Swelling ________ Lymphedema _____________
Constipation or Diarrhea ___________ Cording (Axillary Web Syndrome) __________
Infection ___________ Scar Issues ____________
Any other side effects ____

Chemotherapy: YES/NO Number of Treatments: ______________________________
Dates:
Side effects: Fatigue _______ Nausea or Vomiting _______ Temporary Pain _________
Appetite changes ________ Bruising or Swelling ________ Lymphedema _____________
Constipation or Diarrhea ___________ Chemo Brain _______ Alopecia (Hair Loss) _____
Mouth, Gum, Throat Problems _____________ Weight loss/gain _________
Neuropathy (hands or feet) ____________ Pain, numbness or tingling ________________
Any other side effects ____

Radiation: YES/NO Area/Rounds of Treatments: _________________________
Dates:
Side effects: Fatigue _______ Nausea or Vomiting _______ Temporary Pain _________
Appetite changes ________ Mouth sores _______ Skin irritation ______ Insomnia ______

Lymphedema ____________ Memory problems _______
Constipation or Diarrhea __________
Neuropathy (hands or feet) ___________ Pain, numbness or tingling ______________

Any other side effects ____

Any other treatments (bone marrow transplantation) or therapies (hormone, etc.)?

Did your treatment include any removal or radiation of lymph nodes? YES/NO
If yes, please explain.

Have you experienced lymphedema? YES/NO If yes, please explain.

Have you experienced deep vein thrombosis (blood clots)? YES/NO If yes, please explain.

Has cancer or cancer treatment affected any of the following? (indicate by placing an "x")

____ Lungs ____ Liver ____ Nervous system ____ Heart ____Kidney
____Blood Counts ____ Energy Level _____ or any others not listed? (please explain)

Do you know your current blood count? YES/NO If yes, what is it? ________________

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

Current Nutritional Supplements and Herbs:

Have you tried any complementary and alternative methods for cancer management? YES/NO If yes, please explain.

Describe your energy level today (1-5, 5 being the highest).

Site Restriction Questions.
Do you have any

____ incisions, open wounds, drains or dressings ____ new pain or discomfort
____ skin sensitivity, rash or skin condition ____ other (please explain)
____ IV, port, ostomy, catheter, breast expander/prosthesi
____ a tumor site ____radiation site ____neuropathy ____ lymph node removal or

_____ bone or spine metastasis ______ fracture history radiated
_____ area of infection _____history/risk of blood clot

Pressure Adjustment Questions.

Please indicate if any of the following apply to you.

_____ history or risk of lymphedema (circle one or both)
_____ lymph node removal/radiated
_____ neuropathy in hands or feet
_____ anticoagulants
_____ bone or spine metastasis
_____fragile/sensitive skin
_____ area of pain or burning
_____ recent surgery
_____ easy bruising
_____ low platelet count
_____ steroid medication
_____ fragile veins
_____fatigue
_____ infection or fever
_____ bone fragility/density loss
_____ other (please explain)

Positioning Modification Questions.

When you are on the massage table, should I make any positioning adjustments for you because of

_____ incisions _____medications _____tumor site _____tender skin
_____ breathing difficulty _____ not feeling comfortable with a certain position
_____ swelling or risk of swelling (any body area that needs to be elevated?)
_____ medical devices (please describe) ____
_____ discomfort (please describe) ____

Do you have any of the following? If yes, please explain.

Skin conditions ____

Known allergies ____

Cardiovascular conditions (high/low blood pressure, varicose veins, blood clots, history of heart condition) ____

Liver or Kidney conditions ____

Respiratory or Lung conditions ____

Diabetes ____

Injuries (back, neck, hip or knee) ____

Arthritis or joint problems ____

Digestive problems ____

Other Surgeries ____

Informed Consent:

I, ______________________________, do hereby request and give permission to receive, massage and/or manual lymphatic drainage therapy from The Cancer Wellness Center LLC, and any Licensed Massage Therapist working with them. I understand that I have the right to inquire about and refuse any part of the treatment.
I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment to be in my best interest based on the known facts at the time. Although I am aware that massage therapy has helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

Policies & Procedures:

Appointment Reminders and Follow Up Communication
We may use or disclose your health information to provide you with appointment reminders and follow up communication via phone, voicemail, email or letter.

Privacy Practices
I have reviewed The Cancer Wellness Center LLC's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Payment
- Payment is due at the time of service. We accept cash, checks, and most major credit cards.
- Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 business hours notice you will be charged a $50 fee.
- A $30 fee will be charged for returned checks.
- We reserve the right to change our fee scale without notice.

I have completed this form to the best of my knowledge. I have read and understand the informed consent, privacy, and procedures information. By signing below I agree to a course of treatment in massage therapy and intend this consent form to cover the entire course of treatment for my present condition as well as any future condition(s) for which I seek treatment with this practice.

____
Patient's Name (please print)

____ ____________________
Patient's Signature Date

____ ____________________
Signature of Massage Therapist Date