Cancer Client Intake Form

Your answers to the questions on this form are essential for a safe, effective massage therapy session. Please take some time to answer in detail.

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (day): _____ Phone # (evening): _____

Cell #: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

1. Have you had Massage Therapy before? **Yes** **No** If yes, was there anything that you liked or didn't like?

_____

2. When were you first diagnosed with cancer? _____ What type of cancer? _____

3. Where was/is it located? _____

4. Are you being treated now? **Yes** **No** If no, what was the last date of your last treatment? _____
NOTE: If you are currently in treatment, or if your last treatment session was less than 12 mos. ago, please have your physician complete the accompanying permission form.

5. What treatments have you undergone? *Please supply detail, with dates and types of cancer treatments.*

_____

6. Current medications, not described above: _____

7. Did your treatments include any removal or radiation of lymph nodes? ***(If yes, please describe where.)*** _____	8. Did your treatment include radiation therapy? ***(If yes, please describe areas of your body affected.)*** _____
9. 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 _____ bone or spine metastasis _____ neuropathy _____ fracture history _____ area of infection _____ history or risk of blood clots or phlebitis _____ other ***(please describe)*** _____	10. Do you have any ***pressure restrictions*** due to: _____ history or risk of lymphedema ***(circle which)*** _____ anticoagulants _____ low platelet count _____ bone or spine metastasis _____ steroid medication _____ fragile/sensitive skin _____ fragile veins _____ area of pain or burning _____ fatigue _____ recent surgery _____ infection or fever _____ other ***(please describe)*** _____

11. 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*** _____

12. Has cancer or cancer treatment affected any of the following functions in your body?

_____ Lungs _____ Liver _____Nervous System _____ Heart _____ Kidney

_____ Blood counts _____ Energy level

(Check 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**
13. Any ***swelling*** or ***tendency to swell*** anywhere in your body?			
14. Any sites of ***pain*** or ***tenderness*** anywhere in your body?			
15. Any sites of ***numbness*** or ***reduced sensation*** anywhere in your body?			
16. 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**
17. ***Skin conditions*** (rashes, infections, itching)			
18. Known ***allergies*** or ***sensitivity*** *(if you use any physician-approved lotion on your skin please bring it for the massage therapist to use)*			
19. ***Cardiovascular conditions*** *(for example: heart condition, high blood pressure, angina, hardening of the arteries, history of stoke, severe varicose veins, blood clots)*			
20. ***Liver or Kidney conditions*** *(for example: kidney failure, hepatitis, portal hypertension, etc.)*			
21. ***Respiratory*** *or* ***lung conditions***			
22. ***Diabetes*** *(describe type, any medication, whether blood sugar is well-controlled, any complications)*			
23. ***Injuries*** *(any back problems, knee problems, tendonitis, disc injuries, neck problems, recent fractures)*			
24. ***Arthritis or joint problems***			
25. ***Gastrointestinal problems***			
26. ***Surgery***			