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**Oncology Massage Client History Form**

Name: _____ Today's date_____

Address: _____

Phone Number: home _____ work _____

Date of Birth: _____ Occupation: _____ Referred by:_____

In Case of Emergency Please Notify: _____ Phone: _____

Primary health care provider: _____ Oncologist: _____

Date of last visit?_____ How often do you see your oncologist?_____

What type of cancer have you been diagnosed with?_____

Where was it located? _____ When were you diagnosed? _____

What is the present status of your cancer _____

_____

Has any doctor said anything to you about lymphedema? Yes No
bone metastases? Yes No

Please indicate any cancer treatments you have received (if any).

**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: _____

Area of Treatment: _____ Nodes Irradiated in the neck, armpit, or groin? Yes No

Number of Treatments: _____ Beginning Date:_____ End Date:_____

Area of Treatment: _____ Nodes Irradiated in the neck, armpit, or groin? Yes No

**Surgery/Procedure**:

Type _____ Date_____

Type _____ Date _____

Type _____ Date _____

Were any lymph nodes removed? Yes No Number _____ Where:_____

Reconstruction: Date(s)/Procedure(s) _____

**Please list any other treatments you have had**: _____

_____

**Side Effects of Cancer Treatment**:

(Circle) current conditions Underline past conditions

If needed please include an explanation below.

***GI Conditions***: Nausea Vomiting Low appetite Mouth sores Wt. loss Wt. gain

Diarrhea Constipation

***Musculoskeletal***: Osteoporosis Bone pain Adhesions Incision Headache

Touch/pressure sensitivity Decreased range of motion or function Pain

Former injuries Fractures Joint problems Joint replacement

***Nervous System***: Burn Itch Tingle Prickle Numbness in arms hands legs feet

Memory problems

***Skin***: Skin infection Dry skin Fragile skin Skin irritation Radiation skin reaction

Hair loss

***Circulatory/Blood***: Edema Easy bruising Low platelet Low white count Blood clot

Excessively cold/warm Lymphedema Heart condition High blood pressure

Lung condition

***General***: Fatigue Pain Depression Anxiety Allergies Systemic infection

Infectious condition

***Other side effects***: Current tumor Enlarged nodes/spleen/liver Radioactivity

**Explanations regarding side effects**: (as needed)

**Medical Devices**: (please circle all that apply) IV Catheter Port Breast expander

Breast prosthesis Urinary catheter Ostomy Feeding tube (PEG)

Other_____

**Current Medications and Supplements**:

| Drug name | Purpose | Side Effects |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Do you have any of the following conditions?**

Pregnancy _____ Diabetes ____ Arthritis ____ Heart Disease ____ Varicose Veins ____

Spinal or back problems _____ Headaches _____ High Blood Pressure _____

Osteoporosis _____ Epilepsy or seizures _____ Immune system disorders _____

Hip or knee replacements _____ Joint swelling _____ Fibromyalgia _____ PMS _____

Contagious diseases ____ Circulatory problems _____

Do you have any other medical diagnosis besides cancer? _____

_____

Are you currently receiving medical/therapeutic treatment for any condition other than your cancer diagnosis?

_____

Please list (date and description) any accidents, injuries or surgeries (besides any already mentioned for cancer treatment): _____

_____

Describe any exercise and stress reducing activities you practice (include frequency):

_____

_____

Have you had massage or bodywork before? _____

What is the major complaint you would like to improve?

_____

What activities aggravate the condition? _____

Does this condition interfere with: Work?_____ Sleep? _____ Daily Routine? _____

What have you done to get relief? _____

What do you hope to gain from receiving massage/bodywork?

_____

_____

I realize that the massage session being given here is for well-being of body and mind. This includes stress reduction, relief from muscular tension, spasm or pain or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel my well-being is being compromised.

*I understand that massage practitioners do not diagnose illness, disease or any other physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.*

*I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.*

SIGNATURE: _____ DATE: _____