The Healing ZONE Therapeutic Massage
HYPERLINK "http://www.thehealingzonemassage.com"
www.thehealingzonemassage.com

ONCOLOGY MASSAGE INTAKE FORM

Name: _____ DOB: ___/___/____

Address:_____

_____

Email: _____Phone:_____(cell)_____

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

2. What kind of activities/exercise do you do? _____

3. When were you first diagnosed with cancer? _____ What type of cancer? _____
   Where was/is it located? _____

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

5. What treatments have you undergone? Please supply details and types of cancer treatments.
   _____
   Current cancer medications not described above: _____

6. Current medications for any other condition: _____

7. Did your treatment include any removal or radiation of lymph nodes? Yes____ No_____
   If yes, please describe where: _____

8. Did your treatment include radiation therapy? Yes_____ No_____
   If yes, please describe the areas of your body that were affected. _____
   _____

9. Do you have any position restrictions? Yes_____ No_____
   If yes, please describe where: _____

10. Has cancer/cancer treatment affected any of the following functions in your body?
    ___heart ___kidney ___blood counts ___energy level ___lungs ___liver ___nervous system

11. Do you have any site restrictions due to:

___incisions, open wound, drains or dressings ___IV, port, ostomy, catheter
___skin sensitivity, rash or skin condition ___a tumor site
___bone/spine metastasis ___radiation site
___history/risk of blood clots or phlebitis ___neuropathy
___infected area ___fracture history
___other: _____

12. Do you have any pressure restrictions due to:

___history of lymphedema ___fatigue ___low platelet count
___anticoagulanats ___steroid meds ___fragile/sensitive skin
___bone/spine metastasis ___fragile veins ___fever/infection
___area of pain/burning ___recent surgery
___other: _____

General Signs and Symptoms:	YES	NO	Comments
13. Any swelling or tendency to swell anywhere in your body?			
14. Any sites of pain/tenderness anywhere in your body?			
15. Any sites of numbness or reduced sensation in your body?			
16. Any areas of inflammation?			

Other Medical conditions:	YES	NO	Comments
17. Skin conditions (rash/itching)			
18. Allergies or sensitivities			
19. Cardiovascular concerns (such as blood clots, etc)			
20. Liver/kidney conditions			
21. Respiratory or lung conditions			
22. Diabetes			
23. Injuries			
24. Arthritis or joint problems			
25. Gastrointestinal problems			

26. Surgery			

It is my choice to receive massage therapy. I realize the treatment being given is for the purpose of stress reduction, relief from muscle tension, spasm or pain, or for improving circulation. I have stated all medical conditions and medications.

Signature: _____ Date: _____/_____/_____