**Oncology Massage Intake Form**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today's date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where was it located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the present status of your cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your oncologist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you see your oncologist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery/Procedure: Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lymph nodes removed: Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reconstruction: Date(s)/Procedure(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Chemotherapy:**

Number of Treatments: \_\_\_\_\_\_\_\_\_\_ Beginning Date: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_\_\_\_

Number of Treatments: \_\_\_\_\_\_\_\_\_\_ Beginning Date: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_\_\_\_

Number of Treatments: \_\_\_\_\_\_\_\_\_\_ Beginning Date: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_\_\_\_

Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Radiation:**

Number of Treatments: \_\_\_\_\_\_\_\_ Beginning Date: \_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_\_

Area of Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nodes Irradiated in the neck, armpit, or groin? Yes/No

Number of Treatments: \_\_\_\_\_\_\_\_ Begin Date: \_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_\_

Area of Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nodes Irradiated in the neck, armpit, or groin? Yes/No

Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other: Please list any other treatments or medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical Devices: circle any that apply**

urinary catheter, IV catheter, ostomy, port, breast prosthesis, breast expander, feeding tube (PEG), Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Oncology Massage Intake Form

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Side Effects:** (Circle) current conditions, underline past conditions, Check here if 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/factures/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, hair loss, skin irritation, radiation skin reaction

*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, depression, anxiety, allergies, systemic infection, infectious condition

*Other:* current tumor, enlarged nodes/spleen/liver, radioactivity, other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Current Medications:*

Drug name Purpose Side Effects

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Explanations: (as needed)