JC MASSAGE STUDIO

Oncology Massage Intake Form

Client Information

Name _____ Date _____

Address _____ City, State & Zip _____

Phone_____(Circle: Cell / Home / Work) Email _____

I prefer to receive appointment reminders via: ❑ Text ❑ Phone call/Voice mail ❑ Email

Birthday_____/_____/_____ Occupation_____

Emergency Contact _____ Phone _____

1. Have you had professional massage therapy before? ❑ Yes ❑ No If yes, was there anything you liked or did not like? _____

2. What kind of activities are you able to participate in? _____

   Please describe your current day-to-day or week-to-week activities, if any: _____

   _____

NOTE: If you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of the massage session, please have your Oncologist complete the Physician Approval Form.

Diagnosis & Treatment Information

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

   Is cancer currently active? ❑ Yes ❑ No Where was/is it located?_____

4. Are you currently in treatment? ❑ Yes ❑ No If no, what was the date of your last treatment?_____

5. What treatments (surgeries, reconstruction, chemo, radiation) have you undergone/will you undergo? List beginning and end dates.

   _____

   _____

   _____

6. Did your treatment include any removal or radiation of lymph nodes? ❑ Yes ❑ No If yes, please describe where: _____

7. List current *medications* (for cancer or other condition). Attach separate sheet, if needed:_____

   _____

8. Has cancer or cancer treatment affected any of the following ***functions/areas*** in your body?

❑ Lungs	❑ Heart	❑ Liver	❑ Bone
❑ Nervous system	❑ Kidney	❑ Digestion	❑ Taste

Massage Restrictions

1. Do you have any ***site restrictions for massage*** due to: *(Check any that apply)*

❑ Incisions, open wounds, drains, or dressings
❑ Skin sensitivity, rash or skin condition
❑ IV Where:_____
❑ Port Where:_____
❑ Ostomy Where:_____
❑ Catheter
❑ Other device Where:_____
❑ Tumor site Where: _____

❑ Radiation site Where:_____
❑ Neuropathy Where:_____
❑ Bone or spine mets Where:_____
❑ Fracture history Where:_____
❑ Area of infection Where:_____
❑ History/risk or blood clot
❑ Other (*please describe)* _____
_____

2. Do you have any ***pressure restrictions for massage*** due to: *(Check any that apply)*

- ❑ History or Risk of lymphedema (circle which)
- ❑ Anti-coagulants
- ❑ Low platelet count
- ❑ Bone or spine metastasis
- ❑ Steroid medication
- ❑ Fragile/sensitive skin
- ❑ Fragile veins
- ❑ Area or pain or burning
- ❑ Fatigue
- ❑ Recent surgery
- ❑ Infection or fever
- ❑ Other (*please describe)* _____

3. Do you have any ***position restrictions for massage*** due to**:** *(Check any that apply)*

- ❑ Incision
- ❑ Medication
- ❑ Swelling or risk of swelling (any body area in need of elevating?) Where:_____
- ❑ Ostomy
- ❑ Tumor site
- ❑ Medical devices Where:_____
- ❑ Difficulty breathing
- ❑ Tender skin
- ❑ Discomfort Where:_____

Other Medical Conditions/Side Effects

Add comments if you have or had any of the following:

1. Any ***swelling*** or ***tendency to swell*** anywhere in your body? ❑ Yes ❑ No _____

2. Any sites of ***pain*** or ***tenderness*** anywhere in your body? ❑ Yes ❑ No _____

3. Any sites of ***numbness*** or ***reduced sensation*** anywhere in your body? ❑ Yes ❑ No _____

4. Any areas of *i**nflammation?*** ❑ Yes ❑ No _____

5. ***Skin conditions*** (rashes, infections, itching, dryness, hair loss) ❑ Yes ❑ No _____

6. **Known skin *allergies* or *sensitivities*** (if you use any physician-approved or well-tolerated lotion on your skin, please bring it with you at your session) ❑ Yes ❑ No _____

7. ***Cardiovascular conditions*** (history of heart condition, i.e., high blood pressure, angina, coronary disease, stroke, varicose veins, blood clots, bruising, edema, excessively cold/warm) ❑ Yes ❑ No _____

8. ***Liver*** or ***kidney conditions*** (kidney failure, hepatitis, portal hypertension) ❑ Yes ❑ No _____

9. ***Respiratory*** *or* ***lung conditions*** ❑ Yes ❑ No _____

10. ***Nervous System*** (burning, tingling, numbness in arms/hands/legs/feet, brain fog) ❑ Yes ❑ No _____

11. ***Diabetes*** (Type I or II, any medication, is it under control, any complications) ❑ Yes ❑ No _____

12. ***Injuries*** (back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures) ❑ Yes ❑ No _____

_____

13. ***Arthritis*** *or* ***joint problems*** ❑ Yes ❑ No _____

14. ***Digestive problems*** ❑ Yes ❑ No _____

15. ***Other Non-related Surgeries*** ❑ Yes ❑ No _____

16. ***General*** (fatique, depression, anxiety, sleeplessness, pain) ❑ Yes ❑ No _____

17. **Any other condition not listed above** ❑ Yes ❑ No _____

Please read and sign:

A referral from your primary care provider may be required prior to your session. When no referral is provided the therapist reserves the right to refuse treatment. I understand that massage therapy is solely for the purpose of relaxation. I understand I have the right to refuse treatment at any time during the session. I consent to have therapeutic massage and do not hold the therapist liable for any complications resulting from this massage.

Client Signature _____ Date _____