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
___skin sensitivity, rash or skin condition
___ bone/spine metastasis
___history/risk of blood clots or phlebitis
___infected area
___IV, port, ostomy, catheter
___ a tumor site
___radiation site
___neuropathy
___fracture history
___other: _____

12. Do you have any pressure restrictions due to:

___history of lymphedema ___fatigue ___low platelet count
___anticoagulants ___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 state all medical conditions and medications.

Signature: _____ Date: _____/_____/_____

Dear Physician:
Your patient would like you to read and sign this form. It is the policy of BES Natural Solutions to have this form signed for all clients currently in cancer treatment or between treatment, and those whose last treatment occurred within the past one year. Thank you for completing the form below.

Specially trained massage therapists will administer strokes for the purpose of relaxation and comfort. The session will be specially adapted to the needs of the client. When designing the session, the massage practitioner will honor, among other medical issues, the following:

☐ 1. Sites affected by surgery, radiation, IVs, skin conditions, pain, edema or bone involvement. (The therapist will avoid strong pressure on these sites. If there has been any lymph node dissection or radiation of lymph nodes **with risk of lymphedema**, the therapist will not use pressure on the distal extremity or trunk quadrant, and, if needed, the limb will be elevated during the massage.)

☐ 2. Low platelet levels, easy bruising. (The massage therapist will use gentle skin contact instead of pressure.)

☐ 3. Side-effects of treatments including chemotherapy and radiation therapy. (The therapist will work gently overall in order to avoid aggravating fatigue, nausea, skin changes, etc., and will adapt other elements of the session to any presenting side effects.)

☐ 4. Any risk of deep vein thrombosis, secondary to malignancy, inactivity or cancer treatment. (The massage **therapist will avoid use of pressure on the lower extremities if there is any risk of thrombosis in those areas.)**

It is our experience that clients appreciate the effects of massage therapy. They say they have improved sleeping, less pain and suffering, improved general relaxation, a reduction in nausea and vomiting, less anxiety, and an improved state of mind and well-being.

_____ has permission to receive therapeutic massage
(print name of patient here) as described above.

I have read through the common massage therapy adjustments above**. I have circled the relevant issues for this patient**. Any additional concerns I have are described below:

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_____
_____
Physician's Signature Date

_____
Print Physician's Name