Balanced Body Massage

Oncology Massage Intake Form

Name(Please Print)_____DOB_____Date_____

Address_____City_____State_____Zip_____

Email:_____Phone#_____Occupation:_____

Emergency Contact (Name & Phone) _____

1) How did you hear about Balanced Body Massage?_____

2) Have you ever had a massage before? Yes / No If So, When?_____

3) What are you hoping to achieve with massage? Are there any areas to focus on or avoid?
_____

4) Are there any current conditions that I should be aware of?_____

5) Do you have any allergies?_____

6) May we contact your doctor if a safety consult is required?_____

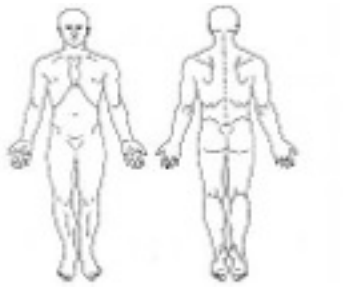
7) Please list any medications/supplements/herbs you currently take:
_____

8) Have you ever had any forms of cancer? Yes / No If so, please list type, dates, and current status: _____

9) Have you had any lymph nodes removed? Yes / No If so, where?_____

10)Please list any surgeries/injuries I should be aware of:_____

11)Please circle the areas of discomfort and areas you would like to focus on:



When were you diagnosed with cancer?_____ Where is/was it located?_____

What type of cancer?_____ Have you received massage since your diagnosis? Yes/No

Are you being treated now? Yes / No If no, what was your last date of treatment?_____

Who is your oncologist?_____

Surgery/Procedure:
Type_____Date_____
Lymph nodes removed:
Number_____Where:_____
Reconstruction: Date(s)/Procedure(s):
_____
Side Effects:
_____

Chemotherapy:

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

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

Number of Treatments:_____ Beginning Date:_____End:_____

Side Effects:
_____

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:
_____

Other: Please list any other treatments or medications:
_____
_____

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

Medical Devices: ___IV ____catheter ____port ____breast expander ____urinary catheter ____ostomy ___feeding tube (PEG) ___breast prosthesis Other_____

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

Other: current tumor, enlarged nodes/spleen/liver radioactivity
other_____

Current Medications: Please list any medications you are currently taking, in addition to any chemotherapy drugs, and any side effects you experience.

Drug name	Purpose	Side Effects

Explanations: (as needed)

To your knowledge do you have any site restrictions due to:

____incisions, open wounds, dressings
____medical devices such as IV or ostomy
____bone or spinal metastases
____tumor site
____history of fractures
____area of infection
_____skin condition, rash, or sensitivity
_____a history of blood clots or phlebitis
_____neuropathy
_____radiation site(s)
_____bone fragility
_____other (please describe)_____

To your knowledge, do you have any pressure restrictions due to:

_____history or risk of lymphedema
_____low platelet count
_____steroid medication
_____fragile/sensitive skin
_____area(s) of pain or burning
_____recent surgery
_____other (please describe)_____
_____anticoagulants
_____bone metastases
_____steroid medication
_____fragile veins
_____fatigue
_____infection or fever

Do you have any position restrictions due to:

_____incision _____medication _____ostomy _____tumor site _____difficulty breathing
_____medical devices _____discomfort _____swelling or rick of swelling
Please list and describe any area requiring elevation_____

Has cancer or cancer treatment affected any of the following functions in your body?

___lungs ___liver ___nervous system ___heart ___kidney ___blood counts ___energy level
If yes, please describe_____

General Signs & Symptoms

Check yes & add further comments if you have had any of the following signs/symptoms	**Yes No**	**Comments**
Swelling or tendency to swell anywhere in your body	**Yes No**	
Sites of pain/tenderness/ numbness/diminished sensation	**Yes No**	
Inflammation	**Yes No**	

Specific Medical Conditions

Check yes & add further comments if you have had any of the following signs/symptoms	**Yes No**	**Comments**
Skin conditions (rashes, infections, allergies, itching)	**Yes No**	

Check yes & add further comments if you have had any of the following signs/symptoms	Yes No	Comments
Known allergies/sensitivities (Do you use any non-allergic or physician-approved lotion?	**Yes No**	
Cardiovascular conditions (e.g. heart condition, angina, high blood pressure, ateriosclerosis, phlebitis, thrombosis, etc.)	**Yes No**	
Liver or kidney conditions	**Yes No**	
Respiratory or lung conditions	**Yes No**	
Diabetes	**Yes No**	
Arthritis	**Yes No**	
Injuries (e.g. disc problems, tendonitis, knee problems, fractures)	**Yes No**	
Surgery	**Yes No**	
Any conditions NOT Mentioned	**Yes No**	

How would you rate your diet? ___Very Healthy ___Somewhat Healthy ___Not Very Healthy ____Needs Improvement

How much uninterrupted sleep do you get each day, on average? ___none ___1-3 hrs ____4-5hrs ____6-7 hrs ____8+ hrs

If you are having trouble sleeping, what is the primary reason? ____anxiety ___pain ___outside interruption(family, noise, etc.) ___other (please explain)_____

On average, how much water do you drink each day? (as a reference, a soft drink can contains 12 oz.) ___Less than one 8 oz. glass ___More than five 8 oz. glasses ___Eight or more 8 oz. glasses

Are you able to relax? Yes / No If so, what do you usually do to relax?_____

Is there anything else that you think I should know?_____
_____

By signing below I declare that, to the best of my knowledge, the above information is accurate. According to informed consent, I acknowledge that I am aware of the possibility of soreness

following the masssage. I am also aware that any massage will be NON-sexual in nature. At any time the therapist or client feels uncomfortable the massage may be terminated immediately.

_____	_____
Client Name Printed	*Licensee's Name*
_____	_____
Client Signature *Date*	*Licensee's Signature* *Date*

Thank You!