

Oncology Massage Intake assessment

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday (mm/dd/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Type of cancer and location: | **Do Any of the following apply to you?****Pressure related side effects:**Easy bruising/ low platelets Y / NAreas of fragile/sensitive skin Y / NFatigue Y / N | **Site-Related Side Effects:**Pain or discomfort\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical devises\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Skin concerns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Radiation burns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Low white count /Neutropenic Y / N | Calf tenderness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| IN treatment now? Y / N | Recent blood clots Y / N | Tumor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Treatment stat date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Lymph node removal (amount)\_\_\_\_\_\_\_\_\_ | Incisions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If applicable when did you END treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Edema Y / NDiagnosed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Have you EVER had massages? Y / N | Lymphedema Y / N | **Positioning adjustments:** |
| Have you had massages since diagnosis Y / N | Sensitivity from radiation Y / N | Pain discomfort\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Which of the following treatments have you received:* Chemotherapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other drug treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Radiation (where/amount) \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Biopsies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Reconstruction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | Bone Fragility Y / NMetastases Y / NWhere\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Neuropathy Y / NReceiving/received treatment or\_\_\_\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Nausea\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Anxiety\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tumor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical deivses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Implants\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Incisions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Radiation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you pregnant? Y / N |  | Do you feel Fatigued Y / N |
| Do you experience hot flashes? Y / N |  |  |
| Do you feel nauseated Y / N |  |  |