

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 / N  Areas of fragile/sensitive skin Y / N  Fatigue 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 / N  Diagnosed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 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 / N  Metastases Y / N  Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Neuropathy Y / N  Receiving/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 |  |  |