ONCOLOGY MASSAGE INTAKE FORM

(This form must be completed, in addition to the standard intake form.)

Name _____ Date _____

Type of cancer _____

Date of diagnosis _____ Status of cancer _____

Type of Treatment (if applicable please give date and location):
Surgery _____
_____
_____
_____

Radiation - location of entry and exit sites? _____
_____

Chemotherapy_____
_____
_____
_____

Have you had any lymph nodes removed? Where? _____

Other _____

Are you experiencing any reactions or side effects from the treatments? _____
_____
_____
_____

Do you have any of the following? (Please explain below)

□ fatigue □ incisions □ skin conditions □ nausea □ bruising □ blood clots

□ medical devices (such as a port) □ positions that you cannot lie in or are uncomfortable

Explanation: _____
_____
_____
_____

Is there anything else about your condition that your therapist should know about?

_____
_____
_____
_____

Is there anything that your therapist will be able to do for you to make your massage experience more comfortable, relaxing, and enjoyable?

_____
_____
_____

By signing below:

- ☐ I have provided a doctor's authorization to receive a massage, if I am still receiving treatment or under a doctor's care for this condition.
- ☐ I understand that my massage therapist may or may not be trained and/or experienced in oncology massage.
- ☐ I hereby voluntarily release my therapist from any liability should my condition be aggravated or reoccur at any time.

Signature: _____ Date: _____