CANCER CLIENT ADDITIONAL INTAKE FORM

Name:_________________________

Cellular/phone number: __________________ ________Date: ____________________

1. Please describe what activities are you able to do each day. Give us a general idea of your current day-today or week-to week activities, if any

    ____

    ____

    ____

2. When, where were you first diagnosed with cancer?___________________________

    ____

    What type of cancer?____

    Is cancer currently active?____

    Where was/is located?____

3. Are you being treated now? Yes○____ No○____

    If no, what was the date of your last treatment? ______________________________

<u>If yes:</u> If you are currently in treatment, between treatments, or if your last treatment session was <u>within one year of this massage session</u>, **<u>please have your physician complete the MD permission form before your massage.</u>**

4. What **<u>treatments</u>** have you undergone? ____________________________________

    ____

    ____

    When?____

5. Please list dates and types of surgery and other treatments	**Date (s)**	**Type of surgery and other treatments**

6. Current **medications** (for cancer or other conditions) not describe above:

____

____

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 where? ____

   ____

9. Do you have any **site restrictions** due to:

___incisions, open wounds, drains, or dressings
___skin sensitivity, rash or skin condition count
___history/risk of blood clot
___bone or spine metastasis
___area of infection
___IV, port, ostomy, catheter or other device. Explain_____

_____

___fracture history
___radiation site
___neuropathy
___tumor site
___other (please describe)

_____

10. Do you have **any pressure restrictions** due to:

___history of risk of lymphedema
___anticoagulants
___bone or spine metastasis
___fragile/sensitive skin
___area of pain or burning
___low platelet
___steroid med
___fragile veins
___fatigue
___infection or fever
___recent surgery describe:

_____

_____

11. Do you have any **position restrictions** due to:

___incision
___medication
___ostomy
___swelling or risk of swelling (any are need elevating? please describe_____

_____

___tumor site
___difficulty breathing
___tender skin

___medical devices? **please describe**_____

___discomfort? **please describe**_____

12. Has cancer or cancer treatment affected any of the following functions in your body? **Current issues**

- ◯ lungs
- ◯ liver
- ◯ nervous system
- ◯ heart
- ◯ kidney
- ◯ blood counts
- ◯ energy level

Please describe: ____

____

____

General signs and symptoms

Check "yes" and add comments if you have or have had any of the following:

	Yes	No	Comments
13. Any **swelling or tendency to swell** anywhere in your body?	◯	◯	
14. Any sites of **pain or tenderness** anywhere in your body	◯	◯	
15. Any sites of **numbness or reduced sensation** anywhere in your body?	◯	◯	
16. Any areas of **inflammation**?	◯	◯	
17. Other **Medical conditions**:	◯	◯	

Check "yes" and add comments if you have or have had any of the following

:	Yes	No	Comments
18. **Skin conditions** (rashes, infections, itching)	◯	◯	
19. Known **allergies or sensitivities** (if you use any physician-approved or well-tolerated lotion on your skin, please bring it for us to use with you	◯	◯	

:	Yes	No	Comments
20. **<u>Cardiovascular conditions</u>** (History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)	◯	◯	
21. **<u>Liver or kidney conditions</u>** (for example kidney failure, hepatitis, portal hypertension, etc)	◯	◯	
22. **<u>Respiratory or lung conditions</u>**	◯	◯	
23. **<u>Diabetes</u>** (describe type, any medication, whether blood sugar is well-controlled, any complications)	◯	◯	
24. **<u>Injuries</u>** (any back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures)	◯	◯	
25. **<u>Arthritis or Joint problems</u>**	◯	◯	
26. **<u>Digestive problems</u>**	◯	◯	
27. **<u>Surgery</u>**	◯	◯	