

Oncology Massage Intake Form  
(Must accompany a complete health history)

Name \_\_\_\_\_ Today's date \_\_\_\_\_

When were you diagnosed? \_\_\_\_\_ What type of cancer? \_\_\_\_\_

Where was it located? \_\_\_\_\_ What is the present status of your cancer? \_\_\_\_\_

Who is your oncologist? \_\_\_\_\_ Date of last visit? \_\_\_\_\_

How often do you see 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 said anything to you about lymphedema? Yes No bone metastases? Yes No

**Medical Devices:** IV catheter port breast expander breast prosthesis  
urinary catheter ostomy feeding tube (PEG) Other \_\_\_\_\_

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**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:**

| Drug name | Purpose | Side Effects |
|-----------|---------|--------------|
| _____     | _____   | _____        |
| _____     | _____   | _____        |
| _____     | _____   | _____        |
| _____     | _____   | _____        |
| _____     | _____   | _____        |
| _____     | _____   | _____        |
| _____     | _____   | _____        |
| _____     | _____   | _____        |

**Explanations:** (as needed)