INTAKE – CLIENTS WITH A HISTORY OF CANCER

Your answers to these questions are essential for a safe, effective massage therapy session. Please take some time to answer in detail.

Name_____ Phone (day)_____(eve.)_____

Address_____

Emergency Contact_____Phone_____

Have you received massage before? Yes/No Was there anything you liked or disliked?

When were you first diagnosed with cancer? _____What type of cancer?_____

Where was/is it located? _____

Are you being treated now? Yes/No If so, what was the date of your last treatment? _____
NOTE: If you are currently in treatment, or if your treatment session was less than 12 months ago, please have your physician complete a permission form. One will be provided.

What treatments have you undergone? *Please be detailed with dates and types of cancer treatments.*

_____

_____

Currents medications not listed above_____

Did your treatment include removal or radiation of lymph nodes? *(If yes, please describe where)*	Did your treatment include radiation therapy? *(If yes, please describe areas of your body affected)*
Do you have any *site restrictions* due to: ___incisions, open wounds, drains or dressings ___Skin sensitivity, rash or skin condition ___IV, port, ostomy, catheter or other device ___tumor site ___radiation site ___bone or spine metastasis ___neuropathy ___fracture history ___infection ___history or risk of blood clots or phlebitis ___other *(please describe)*	Do you have any *pressure restrictions* due to: ___history or risk of lymphedema *(circle which)* ___anticoagulants ___low platelet count ___bone or spine metastasis ___steroid meds ___fragile or sensitive skin ___fragile veins ___area of pain or burning ___fatigue ___recent surgery ___infection/fever ___other (please describe)