Oncology Massage Intake Form *Mei Leslie, LMT, CST-T*
Selah Massage & Bodywork

Client Information

Name _____ Date _____

Address _____ City, State & Zip _____

Phone_____(Circle: Cell / Home / Work) Email _____

I prefer to receive appointment reminders via: ❑ Text ❑ Phone call/Voice mail ❑ Email

Birthday_____/_____/_____ Occupation_____

Emergency Contact _____ Phone _____

1. Have you had professional massage therapy before? ❑ Yes ❑ No

2. What kind of activities are you able to participate in? _____

NOTE: If you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of the massage session, please have your Oncologist complete the Physician Approval Form.

Diagnosis & Treatment Information

3. When were you first diagnosed with cancer? _____ What type of cancer? _____

   Is cancer currently active? ❑ Yes ❑ No Where was/is it located?_____

4. Are you currently in treatment? ❑ Yes ❑ No If no, what was the date of your last treatment?_____

5. What treatments (surgeries, reconstruction, chemo, radiation) have you undergone/will you undergo? List beginning and end dates.

   _____

   _____

   _____

6. Did your treatment include any removal or radiation of lymph nodes? ❑ Yes ❑ No If yes, please describe

   where: _____

7. List current *medications* (for cancer or other condition). Attach separate sheet, if needed:_____

   _____

   _____

Massage Restrictions

1. Do you have any ***site restrictions for massage*** due to: *(Check any that apply)*

❑ Incisions, open wounds, drains, or dressings
❑ Skin sensitivity, rash or skin condition
❑ IV Where:_____
❑ Port Where:_____
❑ Ostomy Where:_____
❑ Catheter
❑ Other device Where:_____
❑ Tumor site Where: _____
❑ Radiation site Where:_____
❑ Neuropathy Where:_____
❑ Bone or spine mets Where:_____
❑ Fracture history Where:_____
❑ Area of infection Where:_____
❑ History/risk or blood clot
❑ Other (*please describe)* _____
_____

2. Do you have any ***position restrictions for massage*** due to**:** *(Check any that apply)*

❑ Incision
❑ Medication
❑ Swelling or risk of swelling (any body area in need of elevating?) Where:_____
❑ Ostomy
❑ Tumor site Where:_____
❑ Medical devices Where:_____
❑ Difficulty breathing
❑ Tender skin
❑ Discomfort Where:_____

3. Do you have any ***pressure restrictions for massage*** due to: *(Check any that apply)*

- ❑ History or Risk of lymphedema (circle which)
- ❑ Anti-coagulants
- ❑ Low platelet count
- ❑ Bone or spine metastasis
- ❑ Steroid medication
- ❑ Fragile/sensitive skin
- ❑ Fragile veins
- ❑ Area or pain or burning
- ❑ Fatigue
- ❑ Recent surgery
- ❑ Infection or fever
- ❑ Other (*please describe)* _____

Other Medical Conditions/Side Effects Add comments if you have or had any of the following:

1. Any ***swelling*** or ***tendency to swell*** anywhere in your body? ❑ Yes ❑ No _____
2. Any sites of ***pain*** or ***tenderness*** anywhere in your body? ❑ Yes ❑ No _____
3. Any sites of ***numbness*** or ***reduced sensation*** anywhere in your body? ❑ Yes ❑ No _____
4. Any areas of *i**nflammation?*** ❑ Yes ❑ No _____
5. ***Skin conditions*** (rashes, infections, itching, dryness, hair loss) ❑ Yes ❑ No _____
6. **Known skin *allergies* or *sensitivities*** (if you use any physician-approved or well-tolerated lotion on your skin, please bring it with you at your session) ❑ Yes ❑ No _____
7. ***Cardiovascular conditions*** (history of heart condition, i.e., high blood pressure, angina, coronary disease, stroke, varicose veins, blood clots, bruising, edema, excessively cold/warm) ❑ Yes ❑ No _____
8. ***Liver*** or ***kidney conditions*** (kidney failure, hepatitis, portal hypertension) ❑ Yes ❑ No _____
9. ***Respiratory*** *or* ***lung conditions*** ❑ Yes ❑ No _____
10. ***Nervous System*** (burning, tingling, numbness in arms/hands/legs/feet, brain fog) ❑ Yes ❑ No _____
11. ***Diabetes*** (Type I or II, any medication, is it under control, any complications) ❑ Yes ❑ No _____
12. ***Injuries*** (back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures) ❑ Yes ❑ No _____

    _____
13. ***Arthritis*** *or* ***joint problems*** ❑ Yes ❑ No _____
14. ***Digestive problems*** ❑ Yes ❑ No _____
15. ***Other Non-related Surgeries*** ❑ Yes ❑ No _____
16. ***General*** (fatigue, depression, anxiety, sleeplessness, pain) ❑ Yes ❑ No _____
17. **Any other condition not listed above** ❑ Yes ❑ No _____

Please read and sign:

I understand that massage is for the purpose of relaxation; and that the therapist does not diagnose illness, disease, or other physical or mental disorder, or prescribe medical treatment. Information exchanged during the session is educational in nature and intended to help me understand my health status. I have reported all my existing/current medical conditions and agree to report any changes as they occur. I understand I have the right to refuse treatment at any time during the session. I consent to have massage and do not hold the therapist liable for complications that may arise as a result of the therapy. A referral from your primary care provider may be required prior to your session. When no referral is provided the therapist reserves the right to refuse treatment.

Client Signature _____ Date _____