

INTERNATIONAL ORANGE

Oncology Massage Intake Form

General:

Name _____ Today's date _____

When were you diagnosed? _____ What type of cancer? _____

Where was it located? _____

What is the current 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 _____ Location: _____

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:

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Radiation:

Number of Treatments: _____ Beginning Date: _____ End: _____

Area of Treatment _____

Nodes Irradiated in the neck, armpit, or groin? Yes No

Number of Treatments: _____ Beginning 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:

(Circle) if current, Underline if past

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 side effects: _____

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Current Medications:

Drug name	Purpose	Side Effects

Explanations + Notes: (as needed)