Client Health History Form for Oncology Massage DATE:____________

Name: ____D.O.B_______________
Address:____
Contact: (H):__________________(C):____________________(W):___________________
Emergency Contact: (NAME)______________________RELATIONSHIP)_____________
Phone (H): _________________ (C): _______________(W): ______________

1) Have you had massage before? **YES NO** If yes, was there anything you liked or didn't like?____
2) What kind of activities are you able to participate in?___________________________

____

a) Please give a general idea of your current day-to-day or week to week activities, if any:

____

____

3) When were you first diagnosed with cancer?________What type of cancer?________
4) Are you being treated now? **YES NO** *If no, what was the date of your last treatment?* ________________________
5) What ***treatments*** have you undergone, when? Please list dates and types of surgery and other treatments.

____

____

____

____

6) Current ***medications*** (for cancer or other condition) not listed above:

____

____

____

7) Did your treatment include any removal or radiation of lymph nodes? **(If yes, please describe where)**____
8) Did your treatment include radiation therapy? **(If yes, please describe where)**

____

9) Do you have site restrictions due to:
____ Incisions, open wounds, drains or dressing
____ Skin Sensitivity, rash, or skin conditions
____ IV port
____ a tumor site ____ radiation site ____ neuropathy
____ bone or spine metastasis ____ fracture history
____ area of infection ____ history/risk of blood clot
____ other **(please describe below)**

____

10) Do you have any pressure restrictions due to:
____ *history* or *risk* of lymphedema **(circle which)**
____ anticoagulants ____ low platelet count
____bone or spine metastasis ____ steroid med

_____ fragile/sensitive skin
_____area of pain or burning
_____ recent surgery
_____ other **(please describe below)**
_____ fragile veins
_____ fatigue
_____ Infection or fever

____

11) Do you have any **position restrictions** due to:
_____ incision _____ medication _____ ostomy _____ tumor site _____ difficulty breathing
_____ tender skin _____ swelling or risk of swelling (any body area needing elevating?)
please describe:____
_____ medical devices **please describe**: ______________________________________
_____ discomfort **please describe**: ____

12) Has cancer or cancer treatment affected any of the following functions in your body? **(circle current issues)**
_____ Lungs _____ Liver _____ Nervous system _____ Heart _____ Kidney
_____ Blood counts _____ Energy level
(Circle any that you are currently experiencing and 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**?			

Other Medical Conditions

Check "yes" and add comments if you have or have had any of the following:	**YES**	**NO**	**COMMENTS**
17) **Skin conditions** (rashes, infections, itching, peeling)			
18) Known **allergies** or **sensitivities** (Bring any MD-approved or well-tolerated lotion to use)			
19) **Cardiovascular conditions** (History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)			
20) **Liver or kidney conditions** (for example kidney failure, hepatitis, portal hypertension, etc.)			

21) **Respiratory or Lung conditions**			
22) **Diabetes** (describe type, any med, whether blood sugar is well-controlled, any complications.)			
23) **Injuries** (back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures)			
24) **Arthritis or Joint problems**			
25) **Digestive problems**			
26) **Surgery**			

* It is my choice to receive therapy. I realize that massage is being given for the well being of my body and mind. This includes stress reduction, relief from tension, spasm or pain, or for increasing circulation and energy flow. I understand that practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a healthcare provider for that service. I have stated all medical conditions that I am aware of and will update this practitioner any time I feel my well being is being compromised. The therapist reserves the right to refuse services for any reasons of safety.

** If you are unable to keep your appointment, please contact me within 24 hours to avoid a $30 cancellation charge.*

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Signature