Heart of Life Massage, LLC

Oncology Intake Form

Name _____ Today's Date _____

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

Where is 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 nose, groin or neck? Yes No

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

Area of Treatment: _____ Nodes irradiated in the nose, groin or neck? Yes No

Side Effects: _____

Other: Please list any other treatments or medications:

_____

_____

Has any Doctor said anything about Lymphedema? Yes No Bone metastases? Yes No

Medical Devices: (please circle) IV catheter port breast prosthesis urinary catheter

Ostomy feeding tube (PEG) Other _____

Side Effects: (please circle) current conditions underline past conditions

Is explanation below? Yes No

GI conditions: nausea vomiting low appetite mouth sores wt. loss wt. gain diarrhea constipation

Heart of Life Massage, LLC

Oncology Intake Form

Musculoskeletal: osteoporosis bone pain adhesions incision headache touch/pressure sensitivity decreased ROM 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 WBC count blood clot(s) excessively cold/warm lymph edema 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_____

Drug Name _____ Purpose _____ Side effects _____

Drug Name _____ Purpose _____ Side effects_____

Drug Name _____ Purpose _____ Side effects _____

Drug Name _____ Purpose _____ Side effects_____

Drug Name _____ Purpose _____ Side effects _____

Explanations: (as needed)

Client signature _____ Date _____

Therapist signature _____ Date _____