East Windsor, NJ 08520
www.MendYourBodyMassage.com
Mendyourbodymassage@gmail.com
Phone: 609-529-1094 Fax: 609-371-2503

Oncology History Form

Your answers to the questions on this form are essential to a safe, effective massage therapy session. Please take some time to answer in detail.

Name: _____ Date: _____
Address: _____
City, State, Zipcode: _____
Home Number: _____ Cell Number: _____
Email Address: _____
Date of Birth: _____
Occupation: _____
Were you referred? Yes No If yes, by whom?_____

In case of emergency, contact: _____
Emergency Contact Telephone: _____

1. Have you had Massage Therapy before? **Yes No** If yes, was there anything you did/did not like?
_____
_____

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

Please give me 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? _____

Is the cancer currently active? _____ Where was/is it located? _____

4. Are you being treated now? **Yes No** If no, what was the date of your last treatment? _____

If no, what was the date of your last treatment? _____

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 physician complete the MD permission form.

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 described above: _____
_____
_____

7. Did your treatment include any removal or radiation of lymph nodes? **Yes No**
(If yes, please describe where): _____

8. Did your treatment include radiation therapy? **Yes No**
(If yes, please describe where): _____

9. 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 (***Circle which one***)
____ 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***)
____ Anticoagulants
____ Low platelet count
____ Bone or spine metastasis
____ Steroid med
____ Fragile/sensitive skin
____ Fragile veins
____ Area of pain or burning
____ Fatigue
____ Recent surgery
____ Infection or fever
____ Other (***Please describe below***)

11. Do you have any ***position restrictions*** due to:

____ Incision
____ Medication
____ Tumor site
____ Difficulty breathing
____ Tender skin
____ Swelling or risk of swelling (Any body area need 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
____ Nervous System
____ Energy Level
____ Liver
____ Blood counts
____ Heart
____ Kidney

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)*			
18. Known ***allergies*** or ***sensitivities*** *(if you use any physician-approved or well-tolerated lotion on your skin, please bring it for us to use with you)*			
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 medication, whether blood sugar is well-controlled, any complications.)*			
23. ***Injuries*** *(any back, neck, hip or knee problems, tendonitis, disc injuries, recent factures)*			
24. ***Arthritis or Joint problems***			
25. ***Digestive problems***			
26. ***Surgery***			