



Oncology Massage Intake Form

Name _____ Today's date _____

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

Where was 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 neck, armpit, or groin? Yes No

Number of Treatments: _____ Begin 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: 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 _____

Current Medications:

Drug name	Purpose	Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Explanations: (as needed)