Intake Form for Clients with Cancer

(Form must be completed and submitted prior to the massage appointment)

1. Have you had massage therapy before? If yes, was it since your cancer diagnosis?

2. What is the cancer status at this point in time?

3. What type of cancer is/was it? Where was or is it in your body?

4. Have you had any recent diagnostic tests, or do you have any scheduled? If so, what is being tested? What kinds of findings were there, or are they looking for?

5. Is there any bone involvement? If so, where? What is your activity level? Are there any medical restrictions on activities or movements? Have any of your health care team—doctors, nurses, physical therapists or occupational therapists—expressed concern about the stability of your bones?

6. Are there any areas of pain or discomfort? If so, where? Is this new or unfamiliar or familiar and well managed from the past? Is it sharp or radiating?

7. Are there any areas of weakness, numbness or sensation changes?

8. How does the cancer affect you?

9. Is there any vital organ involvement? (liver, brain, kidneys, lungs, brain or heart) Is any vital organ function affected by cancer or by the cancer treatment?

10. Are there any effects of cancer or cancer treatment on your blood counts? Are you vulnerable to infection or anemic?

11. Are there any effects of cancer or cancer treatment on blood clotting? Do you have any bruising or bleeding?

12. Are there any complications or other problems caused by cancer?

13. What is your activity or movement level like, day to day or week to week? What is your activity tolerance? Describe your energy level.

14. Are there any medical restrictions on your activity or movement?

15. Are you currently in treatment? Recently? Or are you between treatments?

16. How was or is the cancer treated?
    a. Surgery? When and where on your body? Complications afterward? Were any lymph nodes removed? Any sentinel node biopsy? If so, did your doctor talk with you about risk of lymphedema? Did your doctor or nurse discuss restrictions on blood pressure or anything else in that area?

    b. Chemotherapy? When and how often? How does it affect you? How are your blood counts? Do you have a port or other medical device? If so, where?

c. Radiation therapy? Where on your body? Any markings? How does it affect you? If there is an active or recent radiation field, do you want me to rest my hands on it through the sheet? Were any lymph nodes treated with radiation (in the neck, underarm, groin, pelvis/abdomen) or included in the radiation field?

d. Other treatments, such as stem cell transplant, biologic therapy, hormone therapy or others?

e. Any other medications? Any other medications to prevent cancer recurrence or to manage your symptoms or side effects?

17. If you are taking medication, please answer the following questions:
    a. How do you spell it?
    b. What is it for?
    c. Is it effective?
    d. How does it affect you?

18. How does (or did) the treatment affect you? Are there any complications or side effects?

19. Are there any lingering effects of cancer treatment?