Oncology Massage Consultation Form

Name: .... DOB: ....

Address: ....

Home Phone: .... Mobile: ....

Emergency Contact Person: .... Phone: ....

General & Medical Information

Have you ever had a professional massage? Yes No

Do you experience frequent headaches? Yes No

Are you Pregnant? Yes/No Number of weeks: .... Number of Pregnancies: ....

Any problems on this or other pregnancies? Yes/ No

Details: ....

Are you Diabetic? Yes /No Type A or B: .... If Diabetic it is under control? Yes/ No

Have you ever had a seizure disorder or epilepsy? Yes /No

Do you have cardiac or circulatory problems? Yes /No High or Low blood pressure? Yes /No

Do you have any broken bones/recent surgery/serious injury or serious illness? (in the last 2 years) Yes/No

If yes explain: ....

Do you have any allergies or sensitivity that we should know about? Yes/No

If yes explain: ....

Do you suffer from back or neck pain? Yes/ No

Do you have numbness or pain anywhere? Yes/ No

If yes explain: ....

Are you sore or sensitive to touch or pressure anywhere? Yes/No

Have you taken medication for pain in the last 4 hours? Yes/No

If yes explain: ....

Are you taking Warfarin or any anti-coagulant? Yes/No If yes give details: ....

Do you have any skin conditions such as: Athletes foot cold sores rashes eczema other_______________

Are you receiving or have you ever received treatment for cancer? Yes/No
If yes which therapy: **chemotherapy radiotherapy hormone therapy surgery**
Type of cancer and location: ______________________________ Date of diagnosis: ______________________
Have you had lymph nodes removed, examined or radiated? YES/NO please circle which treatment

Rate your current stress levels between 1 and 10 (10 being the highest). At Home: .... At Work: ....
How long has it been at this level? At Home: .... At Work: ....

Declaration: All of the above information is complete and accurate and I understand it is necessary to inform my therapist if any of the above information changes.

Signed: .... Date: ....

To be completed by your therapist: ______________________________________

SMOKE:	DIET:	ALLERGIES
EXERCISE	MEDICATION	FAMILY HISTORY
RELEVANT CAUTIONS		

STRESS LEVELS	RESPIRATORY	BONES/MUSCULAR
EXCRETORY	DIGESTIVE	REPRODUCTIVE
LYMPHATIC	SLEEP	
POSTURE		

CANCER

Type of cancer and location: __________ Date of diagnosis: ________________ Date treatment finished: __________

Have you had lymph nodes removed, examined or radiated? YES/NO please circle which treatment

POSITIONING ADJUSTMENTS

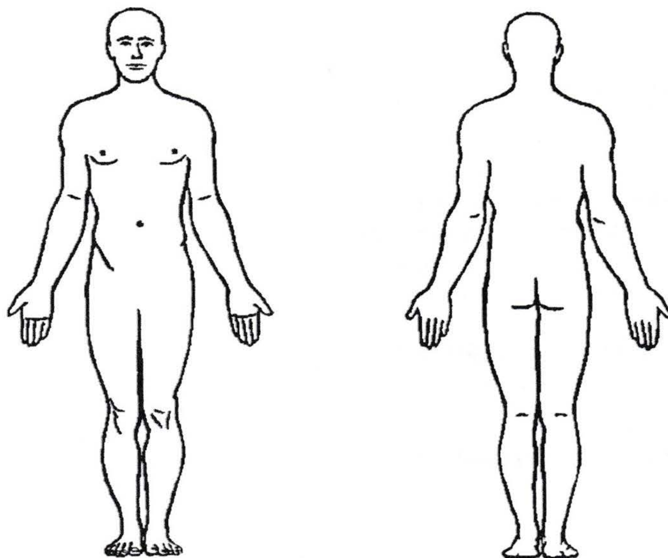
Tumor Radiation burn Medical devices Incisions Nausea Other

What treatments have you received to date:____

____

Are your receiving treatment NOW: YES/NO When did treatment stop:

Pain or discomfort	Easy bruising
Skin problems – fragile or sensitive	Lymph node removal
Neuropathy - numbness	Oedema or swelling
Constipation or diarrhoea	Recent history of blood clot DVT
Bone pain or fragility	Neutropenia–low white cell count
Fatigue	Appetite
Other	



NOTES: ______________________________

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PRESSURE
DURATION
SITE
SKIN
LYMPH NODES
DVT
ENERGY