ONCOLOGY HISTORY

82 Palomino Lane, Suite 501
Bedford, NH 03110
603-627-6381

A history related directly to your oncology diagnosis and treatment is necessary as massage may impact medication effectiveness or worsen existing health conditions. This Information will be used to structure safe therapy sessions for you. New developments should be brought to our attention as they occur.

Name: ____ Date: ________________________

Best Phone: ( ) _______________________ Alt. Phone: ( ) _____________________

____

Address Street City State Zip Code

Email: ___________________________________ Join our Email Newsletter? ☐ Yes ☐ No

Occupation: ____________________________ Sex: M/F Date of Birth: _____________

How did you hear about us so we can send a "thank you" _____________________________________

1. Have you had Massage Therapy before? No Yes If so, was there anything you liked or didn't like?
2. Which activities are you able to participate in OR tell us what you are restricted from doing.

   Please give us 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 cancer currently active? ________ Where was/is it located? ______________________________

4. Are you being treated now? Yes No If no, include the date of your last treatment ____________
   NOTE: if you are currently in treatment, between treatments or if your last treatment session was in the last year, please complete the health information release form.

Primary oncology contact: Name, Phone & Fax Number

____

5. What treatments have you undergone, when? Please list dates and types of surgery and other treatments.

6. Current medications (for cancer or other conditions). Please attach a list if space is not sufficient.

7. Did your treatment include any removal or radiation of lymph nodes? (If yes, please describe where)

8. Did your treatment include radiation therapy? (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)
__ a tumor site __ radiation site __ neuropathy __ fracture history
__ bone or spine metastasis __ 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
__ Anticoagulants __ low platelet count __ bone or spine metastasis
__ Steroid med __ area of pain or burning __ fatigue
__ fragile/sensitive skin __ fragile veins __ recent surgery infection or fever
__ other (please describe)

11. Do you have any position restrictions due to:
__ incisions ___tender skin __ medication __ ostomy ___ tumor site __ difficulty breathing
__ swelling or risk of swelling (does any area need elevating?) please describe ____________________
__ medical devices please describe ____
__ discomfort please describe ____

12. Check if cancer or cancer treatment *has ever* affected any of the following functions in your body.
__ Lungs __ Liver __ Nervous system __ Heart ___ Kidney
__ Blood counts __ Energy Level
Please Circle any above that you are *currently* experiencing decreased function.

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.			

Check “yes” and comment if you have had any of the following:	Yes	No	Comments
17. 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)			
18. Cardiovascular conditions (History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)			
19. Liver or Kidney conditions (for example: kidney failure, hepatitis, or hypertension, etc.)			
20. Respiratory or Lung conditions			
21. Diabetes (describe type, any medication, whether blood sugar is well-controlled, any complications.)			
22. Injuries (any back, neck, hip or knee problems, tendonitis, disc injuries, recent fractures)			
23. Arthritis or Joint problems			
24. Digestive problems			
25. Surgery (note anything not already disclosed in this history form)			

I verify that all information provided is correct and current to the best of my knowledge. I understand that any information provided to my therapist is for exclusive use in providing muscular therapy and will not be discussed with any other persons without my express written permission. I understand that I am responsible for reporting changes in my general health and medications prior to future massage treatments.

____
Signature

____
Date