Marilyn Schonholz LMT **Oncology Massage**

Confidential Intake form

Your answers to the questions on this form are essential for a safe, effective massage therapy session.

Name _________________________**Date of Birth**_________**Tel#**_________________

Address____

Person who referred you____

List all physicians you see____

What is your reason for your visit?____

1. Have you had Massage Therapy before? **Y N** If yes, was there anything that you liked or didn't like?____
2. What type of cancer have you been diagnosed with?________________________
3. When were you diagnosed?____
4. Where was/is it located?____
5. What surgery did you have?____
6. Are you being treated now? Y N
7. If no, what was the date of your last treatment?___________________________
8. What treatments have you undergone with most recent dates?
   Chemotherapy____
   Radiation/Location____
   Radiation Affect on area____
9. Did you have any lymph nodes removed or radiated? **Y N**
   Where?____
10. Do you have any **Site Restrictions** due to(**circle**): incisions, open wounds, drains, dressings, skin sensitivity, rash or skin condition, I.V, port, ostomy, catheter or other device, tumor site, radiation site, area of metastasis, neuropathy, fracture history, area of infection, history or risk of blood clots or phlebitis, other (please describe)____
11. Do you have any **Pressure Restrictions** due to(**circle**): history or risk of lymphedema, anticoagulants, low platelet count, bone metastasis, steroid medication, fragile/sensitive skin, fragile veins, area of pain or burning, fatigue, recent surgery, infection, other(please describe)__________________________
12. Do you have any **Position Restriction** due to(**circle**): incision, dizziness, ostomy, tumor site, difficulty breathing, tender skin, area of swelling needing elevation, medical devices, discomfort, other_____________________________________
13. Has cancer or its treatment affected any of the following(**circle**): lungs, liver, nervous system, heart, kidneys, blood counts, energy level

Past Medical History (please circle if you have the following)
Heart attack, Breathing Problems, Pacemaker, High Blood Pressure, Other Heart Problems, Stroke, HIV?AIDS, Clinical Depression, Diabetes, GERD, Bleeding Problems, Osteoporosis, Blood Clots

Current Medications (include dose, frequency and over the counter meds). If written list available, please give us to make a copy.

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Allergies to medications. Please list medication and the effect it has on you.
Please circle if applies: NONE, Tape, Latex

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Review of Symptoms (Please circle if you have any of the following)
Constitutional: good general health, recent weight change, night sweats
HEENT: hearing loss, sinus problems, nose bleeds, voice change
Eyes: glasses, contacts, blurry or double vision, eye disease or injury, glaucoma
Cardiac: chest pain, palpitations, murmur, swelling of hands or feet
Respiratory: shortness of breath, cough, wheezing, asthma, coughing up blood
Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, rectal bleeding
Musculoskeletal: muscle pain, cramps, stiffness, swelling/pain of joints, trouble walking
Neurological: frequent headaches, paralysis, tremors, seizures
Skin: rashes, itching
Hematologic/Lymphatic: bruising easily, slow to heal, enlarged glands
Urologic: blood in urine, kidney stones, urinary frequency, urinary hesitancy
Psychiatric: insomnia, confusion, memory loss, depression, suicidal thought

LMT notes:

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Client Statement:
To the best of my knowledge, the above information is accurate and complete.

Signed:_______________________________________ **Date:**_________________

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