



**PROVIDER INTAKE NAME:**

**DATE OF RETREAT:**

Oncology Massage Intake Assessment

NAME : \_\_\_\_\_ TEL: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DOCTOR: \_\_\_\_\_

YOUR EMAIL: \_\_\_\_\_ YOUR BIRTHDAY: \_\_\_\_\_

Type of cancer and location:

\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Are you being treated now?  Yes  No

When did you start treatment? \_\_\_\_\_

If applicable when did you finish treatment?

\_\_\_\_\_

Have you ever had a massage or facial?

Yes  No

Have you had a massage or facial since your diagnosis?  Yes  No

Which of the following cancer treatments have you received?

Chemotherapy  Other drug treatments  
 Radiation  Surgery  Reconstruction

Are you pregnant?  Yes  No

Do you experience hot flashes?  Yes  No

Do you feel nauseated?  Yes  No

Do you feel fatigued?  Yes  No

Do any of the following apply to you?

**Pressure-related side effects:**

Easy bruising / low platelets

Areas of fragile / sensitive skin \_\_\_\_\_

Fatigue

Low white count (neutropenia)

Recent history of blood clots

Lymph node removal \_\_\_\_\_

Radiation to neck, axillary area or pelvis

Edema \_\_\_\_\_

Lymphedema \_\_\_\_\_

Bone fragility

Metastases

Neuropathy

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Site-related side effects:**

Pain or discomfort \_\_\_\_\_

Medical devices \_\_\_\_\_

Skin concerns \_\_\_\_\_

Radiation burn \_\_\_\_\_

Recent history of blood clots

Calf tenderness \_\_\_\_\_

Tumor \_\_\_\_\_

Bone metastasis or history of fractures

Incisions \_\_\_\_\_

**Positioning adjustments:**

Pain or discomfort \_\_\_\_\_

Nausea / anxiety / SOB (shortness of breath)

Tumor \_\_\_\_\_

Medical devices \_\_\_\_\_

Incisions \_\_\_\_\_

Radiation burn \_\_\_\_\_

**RELEASE OF LIABILITY:** I understand that it is my responsibility to consult my physician regarding questions included on the Oncology Massage and Skin Care Intake Assessment and any other considerations pertaining to my current medical status that may affect delivery of this service. I further confirm that my answers are complete and correct, and that I have not withheld any information that may be relevant to this service. I release Cancer Concierge Network, its management, employees, contractors, volunteers and all of its agents from any and all liability, foreseeable or not, now in the future.

Participant Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_