_____ Name

Oncology Questionaire

_____ DOB

When were you first diagnosed with cancer? _____ type: _____

Is it currently active? _____ Where was/is it located? _____

Are you being treated now? _____ Date of last treatment? _____

NOTE: if you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of the massage session, please have your physician complete the physician/provider permission form.

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
[ ] a tumor site [ ] radiation site [ ] neuropathy
[ ] bone of spine metastasis [ ] fracture history
[ ] area of infection [ ] history/risk of blood clot
[ ] other _____

Do you have any **pressure restrictions** due to:

[ ] history or risk of lymphedema
[ ] anticoagulants [ ] low platelet count
[ ] bone or spine metastasis [ ] steroid medication
[ ] fragile/sensitive skin [ ] fragile veins
[ ] area or pain or burning [ ] fatigue
[ ] recent surgery [ ] infection or fever
[ ] other _____

Do you have any **position restrictions** due to :

[ ] incisions [ ] medication [ ] ostomy [ ] tumor site [ ] difficulty breathing [ ] tender skin

[ ] swelling or risk of swelling (any area in need of elevating): _____

[ ] medical devices: _____

[ ] discomfort: _____

Has cancer or treatment affected any of the following functions in your body currently?

[ ] Lungs [ ] Liver [ ] Nervous System [ ] Heart [ ] Kidney [ ] Blood counts [ ] Energy Level

explain: _____

_____

Did treatment include removal/radiation of lymph nodes? _____ Where? _____

Did treatment include radiation therapy? _____ Where? _____

What ***treatments*** have you undergone? ***Please list dates and types of surgery and treatments.***

_____

_____

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