A Healing Trail Wellness Center

Client Questionnaire for Oncology Massage

Name _____ Date of Birth _____

E-mail _____ Today's Date _____

Address _____City_____ State____ Zip_____

Home Phone _____ Cell phone or work phone_____
(for blizzard or emergency cancellations only)

Whom can we thank for referring you to us? _____

Occupation _____ My job requires: Driving - Standing - Computers - Sitting -Reaching
(Circle how you spend most of your time)

Have you ever received Professional Massage? **Yes** **No** How frequently? _____

1. When were you first diagnosed with cancer?_____ What type? _____
2. Where is/was the cancer located? _____ Is the cancer active? _____
3. What kind of activities are you able to participate in? _____
4. Please give a general idea of your current day-to-day or week-to-week activities: _____

   _____
5. Are you being treated now? **Yes** **No** If no, what was the date of your last treatment? _____
6. What ***treatments*** have you undergone and ***when***? Please list dates and types of treatments or surgeries:_____

   _____
7. Are you currently taking ***any*** medications? **Yes** **No** What are they?_____
   _____
   _____
8. Did your treatment include any removal or radiation of lymph nodes? If ***yes***, please describe where:
   _____
9. Did your treatment include radiation therapy? If ***yes***, please describe where: _____
   _____

(Over for additional questions → → → → → → → →)

10. 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 or spine metastasis ___ fracture history
___ area of infection ___ history/risk of blood clot
___ other ***(please specify below)***

11. Do you have any ***pressure restrictions*** due to:
___ history or risk of lymphedema (circle which)
___ anticoagulants ___ low platelet count
___ bone or spine metastasis ___ steroid med
___ fragile/sensitive skin ___ fragile veins
___ area of pain or burning ___ fatigue
___ recent surgery ___ infection or fever
___ other ***(please specify below)***

12. Do you have any ***position restrictions*** due to:
___ incision ___ medication ___ostomy ___ tumor site ___ difficulty breathing ___ tender site
___ swelling or risk of swelling (any area of the body that needs elevating?) ***please describe*** _____
___ medical devices ***please describe*** _____
___ discomfort ***please describe*** _____

13. Has cancer or cancer treatment affected any of the following functions in your body?
___ Lungs ___ Liver ___ Nervous system ___ Heart ___ Kidney(s) ___ Blood counts ___ Energy
Circle any that you are ***currently*** experiencing and describe
_____

14. Any ***swelling*** or ***tendency to swell*** anywhere in your body? _____

15. Any sites of ***pain*** or ***tenderness*** anywhere in your body? _____

16. Any sites of ***numbness*** or ***reduced sensation*** anywhere in your body? _____

17. Any areas of ***inflammation***? _____

18. ***ANY*** other medical problems? _____

Does your doctor know you are receiving Oncology Massage? **Yes No**

If needed, may we contact your Doctor regarding your medical condition(s)? **Yes No**

Cancellation Policy

We greatly appreciate as much notice as possible if you have to miss a scheduled appointment. We can usually fill your appointment with 48 hours notice. If you have to give less than 24 hours notice we would appreciate it if you would send a family member or friend in your place. If we can't fill your appointment when you have given less than 24 hours notice, we will bill you for 50% of the session fee.

Your initials here please _____

Doctor's Name and address_____

Your Signature_____