

Name: \_\_\_\_\_ Today's Date \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: (HM) \_\_\_\_\_ (Cell) \_\_\_\_\_ DOB: \_\_\_\_\_

E-Mail: \_\_\_\_\_ (will be used only for professional information)

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Are you currently undergoing or have you recently undergone diagnostic tests? Y N

What was the test for? \_\_\_\_\_

Findings? \_\_\_\_\_

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Type of cancer and location: \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

What is the present status of your cancer? \_\_\_\_\_

Are you being treated now? Y N

If yes, how? \_\_\_\_\_

If no, when did you finish treatment? \_\_\_\_\_

What types of treatment did you receive? \_\_\_\_\_

To what areas of the body? \_\_\_\_\_

Has the cancer (or cancer treatment) affected the function of any of the following organs?

Lungs    Liver    Heart    Brain    Kidney

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Is there any bone involvement? Y N If yes, Where? \_\_\_\_\_

Is your physician concerned about the stability of your bones in those areas? Y N

Has anyone spoken to you about increased risk of fracture in those areas? Y N

Are there any medical restrictions on your activities? Y N

What are your typical daily and weekly movement habits and activities \_\_\_\_\_

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Does your physician approve of them? Y N

Are there any areas of pain? Y N If yes, where? \_\_\_\_\_

Is your physician providing treatment for this pain? \_\_\_\_\_

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Is there anything about the cancer that increases your risk of blood clots? Y N

Has your physician mentioned blood clot or thrombosis as a concern for you? Y N

If yes, did your physician say where in your body was at increased risk? \_\_\_\_\_

Did your physician say why you are at risk? \_\_\_\_\_

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How is your energy level? \_\_\_\_\_

Are there good and bad times of the day? \_\_\_\_\_

**SURGERY:**

How long since surgery? \_\_\_\_\_ Any signs of infection? Y N

Any medical devices still attached? Y N Where? \_\_\_\_\_

Where are incision sites? \_\_\_\_\_

Change in bowel function? Y N

Any lymph node removal? Y N cervical axillary inguinal Where? \_\_\_\_\_

**RADIATION TREATMENT:**

How is radiation therapy affecting you? \_\_\_\_\_

Has is affected your skin, GI tract or bone marrow? Y N

How is the radiation delivered? \_\_\_\_\_ Where? \_\_\_\_\_

How Many? \_\_\_\_\_ How frequently? \_\_\_\_\_

How is the condition of your skin? \_\_\_\_\_

**CHEMOTHERAPY TREATMENT:**

Are you taking any medication as part of cancer treatment? Y N

If so, what are they? \_\_\_\_\_

Any side effects from any of them? \_\_\_\_\_

How is your body responding to chemotherapy? \_\_\_\_\_

How many cycles of chemotherapy have you been through? \_\_\_\_\_

What kind of chemotherapy schedule are you on? \_\_\_\_\_

Are there good and bad times of each cycle that you can predict? \_\_\_\_\_

How has cancer or cancer treatment affected the following?

- Your skin or hair \_\_\_\_\_
- Your muscle tension \_\_\_\_\_
- Your comfort in various positions \_\_\_\_\_
- Your ability to sleep \_\_\_\_\_
- Any areas of pain, stiffness, or changes in sensation \_\_\_\_\_

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. I understand that massage therapists are not qualified to diagnose, prescribe or treat any physical or mental illness. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep Patti-Jo Shaffer, L.M.T. updated as to any changes in my medical profile and understand that there shall be no liability on Patti's part should I fail to do so. My signature below indicates that I understand and agree to the above conditions.

\_\_\_\_\_  
(Client Signature)

\_\_\_\_\_  
(Date)

