



Sacred Grove Holistic Healing and Learning Center

1008 Winscott Road; Suite A O: (469) 309-8243
David Peter Armentano LMT, MTI, CE Provider

Oncology Massage Intake Form

Name: _____ Date of Birth: _____
 Street Address: _____ City: _____
 State: _____ Zip Code: _____ Phone/Cell: _____

- 1) Have you had massage therapy before? Yes ___ No ___ If yes, was there anything that you liked or didn't like? _____
- 2) What kind of activities/exercise do you do? _____
- 3) When were you first diagnosed with cancer? _____
 - a. What type of cancer? _____
 - b. Where was it located? _____
- 4) Are you being treated now? Yes ___ No ___
 - a. If no, when was your last treatment? ____/____/____ (If you are currently in treatment or, if your last treatment was less than twelve (12) months ago please have your physician give a referral note that authorizes treatment.)
- 5) What treatments have you undergone? Please supply details of types of cancer treatments.

Current cancer medications not described above: _____

- 6) Current medications for any other condition: _____
- 7) Did your treatment include the removal or radiation of lymph nodes? Yes ___ No ___
 - a. If yes, please describe where? _____
- 8) Did your treatment include radiation therapy? Yes ___ No ___
 - a. If yes, please describe the areas of your body that were affected. _____

- 9) Do you have any position restrictions? Yes ___ No ___
 - a. If yes, please describe where: _____

10) Has cancer/cancer treatment affected any of the following functions in your body?

- a. Heart ___
- b. Kidney ___
- c. Blood Counts: White Count ___ Red Count ___ Platelet ___
- d. Energy levels ___

11) Do you have any site restrictions due to any of the following (Check all that apply):

___ Incisions, open wounds, drains or dressings	___ IV port, ostomy, catheter
___ Skin sensitivity, rash or skin condition	___ A tumor site
___ Bone/Spine metastasis	___ Radiation Site
___ History/risk of blood clots or phlebitis	___ Neuropathy
___ Infected area	___ Fracture History
___ Other: _____	



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12) Do you have any pressure restrictions due to any of the following (Check all that apply):

- History of Lymphedema Fatigue Low Platelet Count
 Anti-coagulants Steroid Meds Fragile/sensitive skin
 Bone Spine Metastasis Fragile veins Fever/Infection
 Area of pain/burning Recent Surgery
 Other: _____

General Signs and Symptoms	Yes	No	Comments
Any swelling or tendency to swell anywhere in your body?			
Any sites of pain/tenderness anywhere in your body?			
Any sites of numbness or reduced sensation in your body?			
Any areas of inflammation?			
Other Medical conditions:	Yes	No	Comments
Skin Conditions (rash/Itching)			
Allergies or sensitivities			
Cardiovascular concerns (Such as blood clots, etc.)			
Liver/Kidney Conditions			
Respiratory or Lung Conditions			
Diabetes			
Injuries			
Arthritis or Joint problems			
Gastrointestinal problems			
Surgery			

I understand it is my choice to receive massage therapy and that the treatment being given is for the purpose of stress reduction, relief from muscle tension, spasm and/or pain, or for improving circulation. I understand that massage is not a replacement for medical treatment and that my therapist cannot offer diagnosis or treatment, other than massage for any medical conditions I may or may not have as authorized by my treating physician. I also hold no liability to the therapist for any side effects from the massage (nausea, dizziness, vomiting, metastasis of cancer, however unlikely).

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____