Additional Cancer Information **Name**_____ **Date**_____

1. What kind of activities are you able to participate in?_____
   Please give me a general idea of your current day to day or week to week activities, if any._____
   _____
2. When were you first diagnosed with cancer?_____What type of cancer?_____
   Is cancer currently active?_____ Where was/is it located?_____
3. Are you being treated now? **Yes No** If no, what was the date of your 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 massage session, please have your physician complete the MD permission form.

5. What treatments have you undergone, when? Please list dates and types of surgery and other treatments._____
   _____
   _____
   _____

6. Did your treatment include any removal or radiation of lymph nodes? **(if yes, please describe)**
   _____
7. Did your treatment include radiation therapy? **(if yes, please describe)** _____
   _____
8. Do you have any site restrictions due to: **(circle)**
   ____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
   ____area of infection___history/risk of blood clot
   ____other **(please describe below)**

9. Do you have any **pressure restrictions** due to:
   ____history or risk of lymphedema **(circle which)**
   ____anticoagulants ____low platelet
   ____bone or spine metastasis ____steroid med
   ____fragile/sensitive skin ____fragile veins
   ____area of pain or burning ____fatigue
   ____recent surgery ____infection or fever
   ____other **(please describe below)**

10. Do you have any position restrictions due to:
    ____incision____medication____ostomy____tumor site____difficulty breathing____
    ____tender skin____swelling or risk of swelling(any body area need elevating?) _____
    ____medical devices **please describe** _____
    ____discomfort **please describe** _____

11. Has cancer or cancer treatment affected any of the following functions in your body?
    (circle current issues and describe)
    ____Lungs ____Liver ____Nervous system ____Heart ____Kidney
    ____Blood counts ____Energy Level

_____

General Signs and Symptoms Check "yes" and add comments if you have or have had any of the following:	YES	NO	Comments
12. Any **swelling or tendency** to swell anywhere in your body?			
13. Any sites of **pain or tenderness** anywhere in your body?			
14. Any sites of **numbness or reduced sensation**			
15. Any areas of **inflammation?**			

Other Medical Conditions

Check "yes" and comments if you have or have had any of the following:	YES	NO	Comments
16. **Skin conditions**(rashes,infections, itching)			
17. Known **allergies or sensitivities** (if you use any physician-approved or well tolerated lotion on your skin, please bring it with you to use)			
18. **Cardiovascular conditions** (history of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots			
19. **Liver or Kidney conditions** (for example: kidney failure,hepatitis, portal hypertension, etc)			
20. **Respiratory or Lung condition**			
21. **Diabetes** (describe type, any medication, whether blood sugar is well-controlled, any complications.)			
22. **Injuries**(any back,neck,hip,or knee problems,tendonitis,disc injuries, recent fractures)			
23. **Arthritis or Joint** problems			
24. **Digestive problems**			
25. **Surgery**			

Additional cancer info

Have you had a massage since your cancer diagnosis or during cancer treatment Yes__ No__
If so, describe what it was like_____
_____

How have (or did) cancer treatments affect you?_____
_____
How are your blood counts?_____

Are your health providers concerned about any of them?_____
Which ones?_____Any precautions you must take ? _____
Any treatment for low counts?_____ Any side-effects of treatment?_____

Medication	for what condition	effective?	Side-effects