Brookview WELLNESS
HOLISTIC CHIROPRACTIC CARE

**Oncology Massage Intake Form**

**Client's Name: _____ Today's Date: _____**

1. What type of cancer?
2. When were you diagnosed?
3. Where was it located?
4. Who is your oncologist?
5. Date of last visit?
6. How often do you see your oncologist?
7. What is the present status of your cancer?
8. Blood counts (red/white cells):

**Chemotherapy**

Beginning Date: End Date:

Number of treatments:

Side Effects:

**Radiation**

Beginning Date: End Date:

Number of treatments:

What area was treated:

Where the armpit, neck, or groin nodes irradiated:

Side Effects:

**Procedure/Surgery**

What type of procedure/surgery:

Date of procedure/surgery:

Were lymph nodes removed: Yes No

Where and how many:

Procedure(s):

Reconstruction Date:

Side Effects:

**List medical devices such as:** port, catheter, ostomy, etc.

**List current medications:**

**Other information you think would be beneficial for the massage therapist to be aware of:**

**Client Signature: _____ Date: _____**

**Massage Therapist Signature: _____ Date: _____**