NORDIC HOUSE SPA

Specializing in
Lymphedema & Oncology Massage
by Miechelle Juul Hwang CMT/CLT #72480

Oncology Massage Intake Assessment

Name:_____ Tel:_____ Date:_____

Address:_____ Doctor:_____

Email:_____ Birthday (mm/dd/yy)_____

Type of cancer and location:_____

_____

_____

_____

Date of diagnosis:_____

IN treatment now? Y / N

Treatment start date:_____

(If applicable) when did you END treatment?

_____

Have you EVER had massages? Y / N

Have you had massages since diagnosis? Y / N

Which of the following treatments have you received:

- ☐ Chemotherapy _____
- ☐ Other drug treatment_____
- ☐ Radiation (where/amount) _____
- ☐ Surgery_____
- ☐ Biopsies_____
- ☐ Reconstruction_____
- ☐ OTHER_____

Are you pregnant? Y / N

Do you experience hot flashes? Y / N

Do you feel nauseated Y / N

Do Any of the following apply to you?

Pressure related side effects:

Easy bruising/ low platelets Y / N

Areas of fragile/sensitive skin Y / N

Fatigue Y / N

Low white count /Neutropenic Y / N

Recent blood clots Y / N

Lymph node removal (amount)_____

Edema Y / N

Diagnosed?_____

Lymphedema Y / N

Diagnosed?_____

Sensitivity from radiation Y / N

Bone Fragility Y / N

Metastases Y / N

Where_____

Neuropathy Y / N

Receiving/received treatment for anything else: _____

_____

Site-Related Side Effects:

Pain or discomfort_____

Medical devises_____

Skin concerns_____

Radiation burns_____

Calf tenderness_____

Tumor_____

Incisions_____

Positioning adjustments:

Pain discomfort_____

Nausea_____

Anxiety_____

Tumor_____

Medical deivses_____

Implants_____

Incisions_____

Radiation_____

Do you feel Fatigued Y / N