

CANCER QUESTIONNAIRE

Name: _____ Date: _____

Diagnosis of Cancer Type: _____

Are you in remission? _____ If yes, for how long: _____

Name of Oncologist? _____ Phone: _____

Name of any other MD's or ND's you are working with: _____

Do you have your Oncologist's or Primary Physicians approval for massage? _____

Are you working with any other health care practitioners at this time? _____

When were you first diagnosed with cancer? _____

What treatment(s) or therapies have you undergone so far?

- | | |
|--|--|
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Color, Art or Music Therapy |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Spiritual Healing |
| <input type="checkbox"/> Surgery _____ | <input type="checkbox"/> Prayer |
| <input type="checkbox"/> Acupuncture/Oriental Medicine | <input type="checkbox"/> Meditation or Self Healing |
| <input type="checkbox"/> Naturopathy | <input type="checkbox"/> Psychological Counseling |
| <input type="checkbox"/> Herbology or Nutritional Consulting | <input type="checkbox"/> Support Groups |
| <input type="checkbox"/> Massage or other Bodywork | |

Please list all medications you are currently taking (pharmaceutical, herbal or nutritional): _____

Have you had lymph nodes removed? _____ If yes, please describe: _____

What results are you hoping to receive from your massage treatment(s)? _____

What symptoms do you experience as a result of the cancer? _____

Please describe how you are feeling (physically and emotionally) today: _____

Is there anything else you wish to discuss about your cancer, treatments or general health? _____

The above information is accurate and true to the best of my knowledge. I understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for updating my practitioner to any physical, mental or emotional changes that occur with my health. I agree that I am seeking massage voluntarily and have disclosed all medical information in relation to my cancer including but not limited to my symptoms, medications, treatments and state of health. I understand that massage is contraindicated for some forms of cancer and take full responsibility for any and all side effects that may occur.

Signature: _____