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?

- ❒ Chemotherapy
- ❒ Radiation
- ❒ Surgery _____
- ❒ Acupuncture/Oriental Medicine
- ❒ Naturopathy
- ❒ Herbology or Nutritional Consultation
- ❒ Massage or other Bodywork
- ❒ Color, Art or Music Therapy
- ❒ Spiritual Healings
- ❒ Prayer
- ❒ Meditation or Self Healing
- ❒ Psychological Counseling
- ❒ Support Groups

Please list medication 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 your 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: _____