

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

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: