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Client Intake Cancer History

Full Name: _____

Date: _____

Cell phone: _____

Email Address: _____

Address: _____

City: _____

State: _____

Zip: _____

Occupation: _____

Age: _____

DOB: _____

Have you had any form of bodywork before (Chiro Acupuncture etc)? Yes / No

What is the amount of stress/anxiety in your life? 0….1….2….3….4….5….6….7….8….9….10
(none) (average) (extreme)

What physical activities do you do on a daily or weekly basis?

_____

1. When were you first diagnosed with cancer? _____

2. What type of cancer? _____

3. Is cancer currently active? _____

4. Where was/is it located? _____

Are you being treated now? Yes No

If NO, what was the date of your last treatment? _____

If YES:

Chemotherapy? Yes No

If YES: What Chemo agents are you on? _____

External Beam Radiation? Yes No Where? _____

5. Please list dates and types of surgery and other treatments:

6. Current medications (for cancer or other condition - such as anti-coagulant) not described above:

7. Did your treatment include any removal or radiation of lymph nodes? (If yes, please describe where)

8. Do you have any site restrictions due to:

__ incisions, open wounds, drains or dressings

__ skin sensitivity, rash or skin condition

__ PICC, port-o-cath, colostomy bag, catheter, bladder slings, pelvic mesh, lat band, diabetic pump, or other device (circle)

__ a tumor site

__ radiation site

__ neuropathy

__ bone or spine metastasis

__ fracture history

__ area of infection

__ history/risk of blood clot

__ other -- please describe below:

9. Did your treatment include radiation therapy? Yes / No

If yes, do you have any areas that feel stuck? Where:

If yes, did you experience any desquamation? Where:

10. Do you have any pressure restrictions due to:

__ history or risk of lymphedema (circle which)

__ anticoagulants

__ low platelet count (Do you know your INR number today? _____)

__ bone or spine metastasis

__ steroid medication

__ fragile/sensitive skin

__ fragile veins

__ area of pain or burning

__ fatigue

__ recent surgery

__ infection or fever

__ other -- please describe below:

10. Do you have any position restrictions due to:

__ incision

__ medication

__ implanted devices please describe _____

__ tumor site

__ difficulty breathing

__ tender skin

__ swelling or risk of swelling (any body area need elevating?) please describe:

11. Has cancer or cancer treatment affected any of the following in your body? (check current issues)

__ Lungs __ Liver __ Nervous system __ Blood counts __ Energy Level

__ Heart __ Kidney

more detail on any of the above:

_____

GENERAL SIGNS AND SYMPTOMS:

Please indicate if you *currently* have any of the following conditions:

Symptom:	**Yes**	**No**	**Comments**
Any areas of **inflammation**?			
Any **swelling** or **tendency to swell** anywhere in your body?			
Any sites of **pain** or **tenderness** anywhere in your body?			
Any sites of **numbness** or **reduced sensation** anywhere in your body?			

OTHER Medical Conditions:

Condition:	**Yes**	**No**	**Comments**
Skin conditions (rashes, infections, itching)			
Known **allergies** or **sensitivities** (if you use any physician-approved or well-tolerated lotion on your skin, please bring with you)			
Cardiovascular conditions (History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)			**Circle all that apply**: Anemia, Angina, Arteriosclerosis, Congestive Heart Failure, Heart Attack, Heart Murmur, Hemophilia, Hypertension, Varicose or Spider Veins, Other: _____
Liver or Kidney conditions (for example: kidney failure, hepatitis, portal hypertension, etc.)			
Respiratory or **Lung conditions**			
Diabetes (describe type, any medication, whether blood sugar is well-controlled, any complications.)			

Injuries (any back, neck, hip or knee problems,tendonitis, disc injuries, recentfractures)			
Arthritis or Joint problems			
Digestive problems			
Surgery			Date of Surgery: Describe:

Cancellation Policy

Out of respect for Nina's time and others that might be waiting for an appointment, please give at least 24 hrs notice if you must cancel an appointment. The full service fee will be charged with less than 24 hr notice or if you do not show up, emergency situations excluded.

Printed Name _____

Signature _____

Today's Date _____