Oncology Massage
Screening Tool

This screening tool helps the practitioner determine the massage therapy most appropriate for you today.

Name (*please print*) _____ Date _____

Diagnosis _____ Date diagnosed _____

Have you ever received a professional massage? □ yes □ no

Date of last cancer treatment (surgery, radiation, chemo or other) _____

Were lymph nodes ever removed as part of your cancer treatment? □ yes □ no

If yes, how many? _____ Which area of the body? _____

Today do you have or are you experiencing:

□ Infection
□ Fever
□ Rash (location: _____)
□ Neuropathy symptoms such as numbness, tingling, burning of the □ arm □ hand □ leg □ foot
□ Edema/swelling □ arm □ hand □ leg □ foot
□ Skin that easily bruises or tears
□ Medical device (example: port-a-cath, picc line, etc.)
□ Open wounds or an incision
□ Diabetes
□ Other, please explain _____

Have you ever had or experienced:

□ Advice from a physician ***not*** to have massage
□ Tumors
(specify locations) _____
□ Radiation therapy (specify location of the body)
_____
□ Lymphedema □ arm □ leg
□ Surgery
specify type _____ Date _____
□ Deep vein thrombosis □ arm □ leg
□ Bone metastasis
□ Osteoporosis
□ History of fractures if so, where _____
□ Arthritis
□ Other, please explain _____

In the past 3 months have you had or experienced:

□ Light-headedness or fainting
□ Balance problems
□ Chemotherapy □ Oral □ IV
Date began _____ Date ended _____
□ Biotherapy treatment (specify type _____)
Date began _____ Date ended _____
□ Other current ongoing treatment (i.e., stem cell or bone marrow transplant)
please specify _____
□ Low platelet count (below 50)
Most recent platelet count _____ Date _____
□ Blood thinner medication
□ Pain in □ arm □ leg
□ Heat in □ arm □ leg
□ Other, please explain _____

□ **None of the above**

Other:

By the signature below, I hereby give my consent to be the recipient of a relaxation massage session excluding the breast area. I attest that I have provided the therapist with information regarding my known physical and medical conditions, including medications I am currently taking. I understand that if I experience pain or discomfort, I can ask the therapist to change the technique or stop the massage. I understand that if I have any complaint concerning this Licensed Massage Therapist, I may contact the Texas Department of Health, Massage Therapy Registration Program at 512-834-6616 or Complaints Management and Investigative Section, P. O. Box 141369, Austin, TX 78714-1369.

Participant signature: _____