



When were you first diagnosed with cancer? _____

What type of cancer _____

Where was/is it located? _____

Are you being treated now? Yes No

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

NOTE: If you are currently in treatment, or if your last treatment was less than 12 months ago, please have your physician complete the accompanying permission form. Thank you.

What treatments have you undergone? Please supply detail, with dates and types of cancer treatments.

Current medications, not described above: _____

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

Did your treatment include radiation therapy? (If yes, please describe areas of your body affected)

Do you have any site restrictions due to:

- incisions, open wounds, drains or dressings
 - skin sensitivity, rash or skin condition
 - please circle: IV, port, ostomy, catheter, or other device
 - a tumor site
 - radiation site
 - bone or spine metastasis
 - neuropathy
 - fracture history
 - area of infection
 - history or risk of blood clots or phlebitis
 - other (please describe)
-

Do you have any pressure restrictions due to:

- history or risk of lymphedema (circle one)
 - anticoagulants
 - low platelet count
 - 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)
-

Do you have any position restrictions due to:

- incisions
- medication
- ostomy
- tumor site
- difficulty breathing
- tender skin
- swelling or risk of swelling (does any body area need elevating?) please describe:

- medical devices -please describe:

- discomfort -please describe:

Has cancer or cancer treatment affected any of the following functions in your body?

- Lungs
- Liver
- Nervous system
- Heart
- Kidney
- Blood counts
- Energy level

If "yes", please describe:

Please circle and add comments if you have OR have had any of the following:

Any swelling or tendency to swell anywhere in your body? Yes No

Any sites of pain or tenderness anywhere in your body? Yes No

Any sites of numbness or reduced sensation anywhere in your body? Yes No

Any areas of inflammation? Yes No

Skin conditions? (rashes, infections, itching) Yes No

Known allergies or sensitivity? Yes No
(if you use any physician-approved lotion on your skin, please bring it in.)

Cardiovascular conditions? Yes No (for example: heart condition, high blood pressure, angina, hardening of the arteries, history of stroke, severe varicose veins, blood clots)

Liver or Kidney conditions? Yes No (for example: kidney failure, hepatitis, portal hypertension, etc.)

Respiratory or lung conditions? Yes No

Diabetes? Yes No (describe type, any medications, whether blood sugar is controlled, any complications)

Injuries? Yes No (any back problems, knee problems, tendonitis, disc injuries, neck problems, recent fractures?)

Arthritis or joint problems? Yes No

Gastrointestinal problems? Yes No

Surgery? Yes No

Grateful Spirit Massage

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Dear _____,

Your patient, _____ has expressed an interest in receiving massage therapy during the course of her/his treatment. I am writing to you to:

1. Outline some common cautions I use when working with people in cancer treatments.
2. Seek your input on which cautions should be in force with this client.

My Techniques:

With most clients, I use kneading and stroking techniques and apply compressions to the tissue with my hands. I might also do passive stretching and range of motion. I can apply a range of pressures, from just moving the skin (like "lotioning") to deeper muscular work.

Common Adaptations for Clients in Cancer Treatment:

Sites affected by surgery, radiation therapy, IV's, drains, skin conditions, pain, edema, or bone involvement: *I will avoid pressure and often contact at these sites. If there is any nodal involvement with risk of lymphedema, we will use only minimal pressure on the distal extremity and gentle pressure on the trunk quadrant. If needed, the limb will be elevated during the massage.*

Low platelet levels; easy bruising:

I will use gentle strokes that displace the skin and other superficial tissues, not deep muscle layers.

Side-effects of treatments such as chemotherapy and radiation therapy:

I will work gently in order to avoid aggravating fatigue, nausea, etc., and will adapt other elements of the session to any presenting side-effects.

Any risk of deep vein thrombosis, secondary to malignancy, inactivity or cancer treatment:

I will avoid use of pressure on areas at risk of thrombosis in those areas.

Thank you. Please do not hesitate to contact me. Sincerely, Kristin Harrison, LMT

_____(patient's name) has my permission to receive relaxation massage as described above.

I've read through the common massage therapy adjustments, above. I have circled any concerns for this patient. If I have any additional concerns for the massage practitioner, I have described them below:

Physician's Signature

Date

Physician's Signature