Client Medical History Form

Health Fund: **Provider Number:**

Name: _____**DOB:** _____

Address: _____**P/C:** _____

PH (work/home):_____**Mobile:** _____

Occupation: _____**Email:**_____

Next of Kin: _____**Relationship:**_____**Phone:**_____

GP: _____**Phone:** _____

Type of cancer and location:_____

Date of diagnosis: _____Oncologist:_____

Rx received and to what areas of the body?

Y ☐ N ☐ **Surgery:** _____

Y ☐ N ☐ **Chemotherapy:** _____

Y ☐ N ☐ **Radiotherapy:** _____

Are you receiving Rx other than the above?

If yes, what type of treatment? _____

If no, what date did you finish your cancer treatment/s? _____

Pressure Related Considerations

Y ☐ N ☐ Fatigue_____

Y ☐ N ☐ Easy bruising (low platelets) _____

Y ☐ N ☐ Neutropenia (low white cell count) _____

Y ☐ N ☐ Neuropathy: fingers, hands and/or feet _____

Y ☐ N ☐ Lymph node removal: Axilla, Neck, Groin, Abdo, Popliteal Fossa_____(___ x Ca)

Y ☐ N ☐ Oedema or Lymphoedema _____

Y ☐ N ☐ Bone density loss_____

Y ☐ N ☐ Central line in situ _____Date removed:_____

Y ☐ N ☐ Other _____

Created by Tania Shaw and gifted to OMT by her generosity and compassion 2012

Site Related Considerations

- ☐ Pain or Discomfort
- ☐ Incisions
- ☐ Area that feels unusually warm
- ☐ Skin Integrity (scarring, healing issues etc)
- ☐ Other medical devices
- ☐ Tumour
- ☐ Recent Hx of Blood Clots
- ☐ Other

_____

_____

_____

_____

Other Significant Medical History (Surgeries, Diabetes, Vital Organs, Infectious Diseases, BP, GI, Accidents, Injury etc)

_____

_____

_____

_____

_____

_____

Positioning Adjustments:

_____

I confirm, and understand, that:

the Oncology Massage Therapist (OMT) has, to the best of my knowledge, my full medical history, and I give permission for the treatment session to proceed. The OMT will adjust the oncology massage to suit my current health status and there is the (unlikely) possibility of slight bruising and/or 1-2 days of musculature discomfort following the oncology massage. Unless fluid restrictions apply, hydration to my comfort level is encouraged.

Confidentiality is respected and at no time is any information received from me during the Oncology Massage sessions given to any other person, except with my express permission. Photographs may be taken for client progress notes, and/or communication with other health professionals. De-identified photos may be shared via Social Media, and/or educational courses, for educational purposes only; there will not be any financial or otherwise reimbursement for the use of the photographs.

The Oncology Massage is given with all due care and practiced with professionalism in a responsible manner by:

_____

Signature: _____ Date: _____

(Print name): _____