



Providence Cancer Center  
3851 Piper U264  
Anchorage, AK 99508  
907-230-5258

**Personal Health Information**  
*All information given is confidential*

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Birthdate \_\_\_\_\_ Occupation \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Permission to consult \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**Massage History/Treatment Information**

Have you ever received a professional massage before? \_\_\_\_\_ Date of last massage \_\_\_\_\_

Please check the areas you give permission to be worked on: Back \_\_\_ Legs \_\_\_  
Arms \_\_\_ Buttocks \_\_\_ Abdomen \_\_\_ Chest (Pecs) \_\_\_ Neck \_\_\_ Head \_\_\_ Face \_\_\_  
Feet \_\_\_

Are you currently seeing a health care provider? If yes please explain \_\_\_\_\_  
\_\_\_\_\_

List the types of stress reduction and exercise activities you do and their frequencies:  
\_\_\_\_\_  
\_\_\_\_\_

List current medications: Please include aspirin, ibuprofen etc.

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

Other \_\_\_\_\_

Surgeries: \_\_\_\_\_

Accidents: \_\_\_\_\_

What are your goals for your massage sessions: \_\_\_\_\_  
\_\_\_\_\_

Health History

- |  |   |   |                                    |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Bone or joint disease | <input type="checkbox"/> Tendonitis                                   | <input type="checkbox"/> Bursitis         | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Fractures             | <input type="checkbox"/> Sprain/Strain                                | <input type="checkbox"/> Spasms/Cramps    |                                    |
| <input type="checkbox"/> Heart condition       | <input type="checkbox"/> Varicose veins                               | <input type="checkbox"/> Blood clots      | <input type="checkbox"/> DVT       |
| <input type="checkbox"/> Lymphedema            | <input type="checkbox"/> High Blood pressure                          |   |                                    |
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Rashes                                       | <input type="checkbox"/> Athletes foot    |                                    |
| <input type="checkbox"/> Constipation          | <input type="checkbox"/> Diarrhea                                     | <input type="checkbox"/> Diverticulitis   | <input type="checkbox"/> IBS       |
| <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> HIV/AIDS                                     | <input type="checkbox"/> Herpes/ Shingles | <input type="checkbox"/> Numbness  |
| <input type="checkbox"/> Burning pain          | <input type="checkbox"/> Surgery/radiation to armpit/groin/neck areas |   |                                    |

Are you pregnant at this time? \_\_\_\_\_ if yes what stage \_\_\_\_\_

Do you have a history of cancer: \_\_\_\_\_ Type \_\_\_\_\_ Location \_\_\_\_\_

Treatment involved \_\_\_\_\_

I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status. I understand this is for the safety of myself as well as my practitioner.

Client signature \_\_\_\_\_ Date \_\_\_\_\_

Oncology Intake

Client \_\_\_\_\_ Date \_\_\_\_\_

Type of CA and location: \_\_\_\_\_ Date of Dx \_\_\_\_\_

Present status of CA \_\_\_\_\_ Mets \_\_\_\_\_

Current Tx \_\_\_\_\_ When complete \_\_\_\_\_

Hx of Tx \_\_\_\_\_

Date of last blood work: \_\_\_\_\_ Results: \_\_\_\_\_

Side effects of tx:

- |                    |                               |                 |            |
|--------------------|-------------------------------|-----------------|------------|
| ___ easy bruising  | ___ fatigue                   | ___ Hx of clots | ___ DVT    |
| ___ neuropathy     | ___ node removal or radiation |                 | ___ pain   |
| ___ fragile skin   | ___ osteoporosis              | ___ incisions   | ___ port   |
| ___ medical device | ___ tumor                     | ___ nausea      | ___ edema  |
| ___ Hx of Fx       | ___ heaviness in limbs        |                 | ___ emesis |

Other: \_\_\_\_\_

Stress level \_\_\_\_\_

Sleep \_\_\_\_\_

Appetite \_\_\_\_\_

Digestion \_\_\_\_\_

Elimination \_\_\_\_\_

Night Sweats \_\_\_\_\_

Chills/fever \_\_\_\_\_

Diarrhea/constipation \_\_\_\_\_

Anxiety \_\_\_\_\_

Palpitations \_\_\_\_\_

Depression \_\_\_\_\_

Nausea/vomit \_\_\_\_\_

Bone pain \_\_\_\_\_

Immune \_\_\_\_\_

Fatigue \_\_\_\_\_

Neuropathy \_\_\_\_\_

Family support \_\_\_\_\_

Support group \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**S**

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