RIO MASSAGE & WELLNESS: For patients who are living with cancer and those in recovery

NAME_____ Date_____

THERAPIST_____

1. Type of cancer and location_____

2. Date of diagnosis_____

3. Are you being treated now? No_____Yes_____

If yes, how?

_____

If no, when did you finish treatment

_____

4. What other types of treatments have you received and to what areas of the body?

Radiation: No____Yes____ _____

Chemotherapy: No____Yes____ _____

Surgery: No____Yes____ _____

Other: No____Yes____ _____

5. Do you have any side effects as a result of treatments?

Pressure-related side effects:

Fatigue	Radiation Tx to axilla, neck, or groin
Easy bruising (low platelets)	Edema or lymphedema
Low white count (neutropenia)	Bone density loss
Neuropathy in the hands and/or feet	Limb with central line
Lymph node removal: axilla, neck, or groin	Other

Site-related side effects:

Pain or discomfort	Other medical devices
Incisions	Tumor
Area that feels unusually warm	Recent Hx blood clots
Skin problems	Other