Gentle Touch Bodywork 11000 Spain Bldg. E, Abq. 87111
(505) 293-3703 form # 2

Patient_____ Date_____
Oncology Doctor Name(s) _____
Type of cancer, location, stage_____
Surgery? No Yes Describe_____
Are you undergoing treatment? Chemo Radiation Other
_____

Have you been diagnosed with lymphedema? Yes No
Lymph node removal? Yes (Location & #_____) No
How is your energy level? High Medium Low
Do you bruise easily? Yes No
Medications for pain? Yes No
Previous Radiation Yes No Location_____
Bone density? Good Poor
Recent treatment for blood clot? Yes No
Blood counts (red normal 150-400) (white normal 4.5-10)_____

Are there any places I should avoid? Perhaps because of a:
Medical device (pic, port)_____
Painful area_____
Surgical site_____
Neuropathy_____
Other (observations: cracked skin/edema)_____
_____

Are you experiencing any side effects from the cancer, chemo, radiation, or medication that you are aware of? _____
_____
_____

Medications you are taking: (What and for what?)_____
_____
_____
_____
_____

Herbs and Nutritionals you are taking: (What and for what?)_____
_____
_____
_____

Have you received a professional massage before? Yes No

What would you like from this session? (Reduction in pain, stress, fatigue, GI issues, etc.)
_____
_____
_____