Hamid Shibata Bennett, LMT, CAMT OBMT #301 ~ 503-975-1259

Oncology Intake Form 1 of 2

Name:	Date of birth:
Mailing address:	Phone number:
	E-mail:
GENERAL HEATLH QUESTIONS: Circle any that apply to you	
Allergies to scents/oils	Kidney problems
Arthritis or other bone/joint condition	Injury
Chronic pain / acute pain	Heart/circulatory condition
Diabetes	Neurological condition
Fatigue	Pregnancy
Skin disorder / rash	Surgery (recent or past)
CANCER TREATMENT HISTORY When were you diagnosed with cancer?	
What type of cancer were you diagnosed with and where was it?	
What treatments have you had? Please list type of treatment and when you had it.	
Did you have any lymph nodes removed or radiated? If so, where?	

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Oncology Intake Form 2 of 2

Infection

SITE RESTRICTIONS: Circle any that apply

Skin sensitivity / condition / rash

Medical devices (port, catheter, etc)	Neuropathy
Radiation site	History or risk of blood clots
Bone or spine metastis	Other:
PRESSURE RESTRICTIONS: Circle any tha	t apply
Anti-coagulants or steroids	Fatigue
Metastasis	Low platelets
Fragile skin	Recent surgery
Fragile veins	Lymphedeme history or risk
Pain	Other:
POSITION RESTRICTIONS: Circle any that	t apply
Medical devices	Ostomy
Pain / discomfort	Tumor site
Swelling or risk of swelling	Trouble breathing
Incision	Other:
therapy and bodywork is for therapeutic purpo therapy does not take the place of a physicians Cancellation policy: Appointments must be car	ncelled 24 hours in advance. In the case of an emergency, I agree to pay any current
Signature:	
	egal guardian:
Notes (for office use only):	