Intake Questionnaire for Brain Tumor Clients

Name: ______________________ Referred by: ______________________

Primary Caregiver: ______________________ Relation to Client: ______________________

Address: ____

Home phone: ______________________ Fax: ______________________

eMail: ______________________ Blood type (ABO): __________

Age: ________ Height: ________ Weight now: ________ Usual weight (if different): ________

Date of diagnosis: ______________ Tumor Type/Stage: ______________________

Tumor Location (right or left hemisphere? where in brain?): ______________________

Name/phone/address of doctor(s) treating you: ______________________

____

Tell me about the circumstances that led to your being diagnosed with a brain tumor.

List any medications you are currently taking. Please list all prescription and over-the-counter medications.

DRUG NAME	*DOSE*	*REASON TAKING?*	*HOW LONG TAKING?*

List all dietary supplements—including vitamins, minerals, amino acids, herbs, and homeopathic remedies.

BRAND	*PRODUCT NAME / DESCRIPTION*	*DOSE*	*REASON TAKING?*

Are you now using (or have you used) any alternative or complementary therapies?

TREATMENTor THERAPY	*DOSE*	*DATE BEGAN – ENDED?*	*SIDE EFFECTS?*	*RESULTS?*

MEDICAL TREATMENTS

Did you have an initial surgery to remove the tumor? (Please specify if your tumor has been deemed inoperable.)

DATE	*SURGEON*	*HOSPITAL*	*AMOUNT REMOVED*	*COMPLICATIONS?*

Have you had any additional surgeries for recurrence, cyst drainage, shunt placement or necrosis removal?

DATE	*SURGEON*	*HOSPITAL*	*REASON FOR SURGERY?*	*COMPLICATIONS?*

Have you had radiation therapy?

DATES	*TYPE AND DOSE?*	*SIDE EFFECTS?*	*WAS IT EFFECTIVE?*

Have you had chemotherapy?

DATES	*NAME OF DRUG(S)?*	*HOW MANY COURSES?*	*SIDE EFFECTS?*	*WAS IT EFFECTIVE?*

Have you had Gamma Knife, Cyber knife or stereotactic radiosurgery?

DATES	*TYPE OF TREATMENT?*	*SIDE EFFECTS?*	*WAS IT EFFECTIVE?*

Have you participated in any experimental therapies or clinical trials?

DATES	*TYPE OF TREATMENT?*	*SIDE EFFECTS?*	*WAS IT EFFECTIVE?*

When was your most recent MRI, CT or PET scan? What did the results show (compared to your previous scans)?

What are your plans (or your doctor's recommendations) for your next treatments? When are you scheduled to begin receiving these treatments?

CURRENT HEALTH STATUS

What is your current Karnofsky score? ____________ [Ask you doctor or rate yourself: **100**=normal, no evidence of disease; **90**=able to carry on normal activities, minor signs/symptoms of disease; **80**=normal activity with some effort, some signs/ symptoms of disease; **70**=cares for self, unable to carry on normal activities or do active work; **60**=requires occasional assistance but is able to care for most personal needs; **50**=requires considerable assistance and frequent medical care; **40**=disabled, requires special care and assistance; **30**=severely disabled, hospitalization indicated; **20**=very sick, hospitalized or in hospice]

Please (circle) any of the following symptoms you are ***currently experiencing***. If you have had this symptom ***in the past***, but are not experiencing it now, please underline it.

headaches	seizures	muscle weakness	muscle cramps
loss of appetite	nausea	weight loss	weight gain
increased appetite	trouble walking	numbness in hands/feet	fatigue
loss of taste/smell	vomiting	constipation	diarrhea
balance problems	excessive sleep	insomnia	depression
night sweats	low WBC counts	poor short-term memory	infection(s)
difficulty swallowing	low RBC counts	personality changes	anxiety
trouble quitting decadron	double vision	loss of peripheral vision	ringing ears
cognitive changes	speech difficulties	loss of use or hand/arm/leg	mental confusion

drug reaction (specify): ____

OTHER symptoms (please list): ____

What are your goals for your health?

What three factors in your life do you feel are most important to your daily health?

HEALTH HISTORY

Please circle any of the following health conditions you've experienced and write the approximate year in the box:

[ ] pneumonia	[ ] tuberculosis	[ ] hepatitis	[ ] jaundice
[ ] diabetes	[ ] hypoglycemia	[ ] epilepsy	[ ] kidney stone
[ ] skin boils	[ ] psoriasis	[ ] hives	[ ] eczema
[ ] anemia	[ ] kidney infection	[ ] gout	[ ] osteoarthritis
[ ] drug reaction	[ ] migraines	[ ] asthma	[ ] rheumatoid arthritis
[ ] low blood pressure	[ ] obesity	[ ] heart disease/attack	[ ] cancer
[ ] high blood pressure	[ ] high cholesterol	[ ] stroke	[ ] fungal infection
[ ] mental breakdown	[ ] autoimmune dx	[ ] parasites	[ ] candida
[ ] measles	[ ] mumps	[ ] chicken pox	[ ] polio
[ ] whooping cough	[ ] diptheria	[ ] colitis	[ ] herpes
[ ] rheumatic fever	[ ] malaria	[ ] blood transfusion	[ ] dental/gum disease

List any other operations/surgeries (type and year), illnesses, injuries or hospitalizations.

DIET AND LIFESTYLE

Do you have trouble with your digestion (gas, belching, bloating, uncomfortable sense of fullness)? [ ] YES [ ] NO

List any particular foods (or food groups) that upset your digestion. ______________________

____

Do you adhere to a particular diet? ______________________

Do you have any allergies or food intolerances? [ ] YES [ ] NO To what? ______________________

____

Do you use any foods made with chemical additives, preservatives or artificial sweeteners? What? How often?

____

____

Are you able to exercise [ ] YES [ ] NO Is your exercise level [ ] mild [ ] moderate [ ] strenuous?

List exercise activities and frequency: ______________________

____

Do you sleep well? [ ] YES [ ] NO How many hours nightly? ______________________

What are your indulgences? How often? ______________________

ETIOLOGICAL FACTORS

The cause of brain tumors is currently unknown. We do know, however, that there is no single cause of cancer, but rather an interplay of genetics, environment, diet and lifestyle. I am collecting data on the following contributing factors for research purposes. Please specify any factors which you feel may have contributed to your having a brain tumor.

[ ] Use of cell phone: [ ] Less than 1 hour per day [ ] More than 1 hour per day How many years? __________

[ ] Work in one or more of the following occupations? (please circle and indicate number of years)__________

Plumbing	Roofing/Sheet metal	Heating/Air conditioning	Rubber or plastic manufacture
Computer industry	Electronics industry	Mechanic or gas station	Apparel/Textile industry

[ ] Known exposure to radiation, petrochemicals, solvents, dyes, formaldehyde, pesticides, or toxic chemicals? Describe:

____

[ ] Live near known toxins: [ ] electrical power plant [ ] airport [ ] industrial chemicals or [ ] agricultural area?

[ ] Live in a geographical region with a known Brain Tumor Cluster? ______________________

[ ] Use of aspartame (NutraSweet). How much/often? ______________________

[ ] Use of nitrate-containing meats (bacon, sausage, lunch meats, hot dogs). How often? ______________________

[ ] History of intestinal disturbances? [ ] chronic constipation [ ] colitis [ ] irritable bowel [ ] polyps

[ ] History of head injury? Describe. ______________________

[ ] Family history of cancer? Who/which type of cancer? ______________________

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Is there any additional information you would like to add?

Thank You!