

# Intake Questionnaire for Cancer 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): \_\_\_\_\_

Tumor Type/Stage: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_ Any metastases? Where? \_\_\_\_\_

Name/phone of oncologist: \_\_\_\_\_

Tell me about the circumstances that led to your being diagnosed with cancer.

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

<u>DRUG NAME</u>	<u>DOSE</u>	<u>REASON TAKING?</u>	<u>HOW LONG TAKING?</u>
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List all dietary supplements—vitamins, minerals, amino acids, herbs, etc. (Provide full list of ingredients):

<u>BRAND</u>	<u>PRODUCT NAME/DESCRIPTION</u>	<u>DOSE</u>	<u>REASON TAKING?</u>
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Are you now using (or have you used) any alternative or complementary therapies?

<u>TREATMENT OR THERAPY</u>	<u>DATE BEGAN – ENDED</u>	<u>SIDE EFFECTS?</u>	<u>RESULTS?</u>
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## **TREATMENTS**

Did you have an initial surgery to remove the tumor?

DATE                      TYPE & EXTENT OF SURGERY                      COMPLICATIONS?

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

DATE                      TYPE & EXTENT OF SURGERY                      COMPLICATIONS?

Have you had radiation therapy (including radiosurgery or implantation of radioactive seeds or liquid)?

DATES                      BODY LOCATION                      DOSE (Gy/Rads)                      COMPLICATIONS?                      WAS IT EFFECTIVE?

Have you had chemotherapy?

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

Have you participated in any experimental therapies or clinical trials?

DATES                      TYPE OF TREATMENT                      PHASE I, II or III?                      SIDE EFFECTS?                      WAS IT EFFECTIVE?

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

If your doctor is measuring your cancer markers (CEA, PSA, CA19-9, CA125), what are the most recent results?

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

## **CURRENT HEALTH STATUS**

What is your current ECOG Performance Status? [Ask your doctor or rate yourself] Circle one below:

- 0** = Fully active, able to carry on all pre-disease performance without restriction.
- 1** = Restricted in physically strenuous activity, but ambulatory and able to carry out work of a light or sedentary nature (e.g., light house work, office work).
- 2** = Ambulatory and capable of all self care but unable to carry out any work activities. Up and about more than 50% of waking hours.
- 3** = Capable of only limited self care, confined to bed or chair more than 50% of waking hours.
- 4** = Completely disabled. Cannot carry on any self care. Totally confined to bed or chair.

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.

fatigue	pain	muscle weakness	bloating
loss of appetite	nausea	weight loss	weight gain
loss of taste/smell	vomiting	constipation	diarrhea
balance problems	excessive sleep	insomnia	depression
fever	low WBC counts	poor short-term memory	anxiety
night sweats	low RBC counts	seizures	headaches
infection(s)	edema (swelling limbs)	mental confusion	numbness

drug reaction (specify): \_\_\_\_\_

OTHER symptoms (please list): \_\_\_\_\_

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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 had and write the approximate year in the box:

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

List any operations or surgeries (type and year). Any other major illnesses, injuries, or hospitalizations? What and when?

## **DIET AND EXERCISE**

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? \_\_\_\_\_

What percent of your food is from [\_\_\_\_\_] restaurants [\_\_\_\_\_] prepared at home?

What percentage of your diet is [\_\_\_\_\_] raw [\_\_\_\_\_] cooked?

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

Do you exercise?  YES  NO  UNABLE Is your exercise level  mild  moderate  strenuous?

List exercise activities and frequency: \_\_\_\_\_

## **GENERAL QUESTIONS**

Are you able to express your emotions and feelings?  YES  NO

Is there any emotion you feel predominantly?  anger  fear  sadness  worry  depression  other?

Do you sleep well?  YES  NO How many hours nightly? \_\_\_\_\_

Are you happy with your energy level?  YES  NO

Is there a low point in your day  YES  NO When? \_\_\_\_\_

What are your indulgences? How often? \_\_\_\_\_

## **ETIOLOGICAL FACTORS**

Please specify any factors which you feel may have contributed to your developing cancer [e.g., family history of cancer; exposures to chemicals, toxins, pollutants or electromagnetic fields; prolonged or severe stress; malnutrition; functional bowel disturbances (history of chronic constipation, diarrhea, Irritable Bowel Syndrome)].

Is there any additional information you would like to add?

*Thank You!*