Intake Questionnaire for Breast 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? ____________________

Hormone Status (*please circle*): [Estrogen: + vs —] [Progesterone: + vs —] [Her2neu: + vs —]

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 medicines)

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

List all dietary supplements—vitamins, minerals, amino acids, herbs, etc. (Provide full list of ingredients):

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

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

TREATMENT OR THERAPY	*DATE BEGAN—ENDED*	*SIDE EFFECTS?*	*RESULTS?*

TREATMENTS

Did you have an initial surgery (lumpectomy or mastectomy) to remove the tumor?

DATE	*TYPE & EXTENT OF SURGERY*	*COMPLICATIONS?*

Have you had any additional surgeries for cancer?

DATE	*TYPE & EXTENT OF SURGERY*	*COMPLICATIONS?*

Have you had chemotherapy?

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

Have you had radiation therapy?

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

Have you had hormonal therapy (Tamoxifen, Femara, Aromosin, Arimidex)?

DATES	*NAME OF DRUG(S)*	*HOW LONG TAKING?*	*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, CA19-9), what are the most recent results?

If your doctor is monitoring you with diagnostic scans (CT, X-ray, Mammogram, or UltraSound), what do the results show for the last scan (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 strenous 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	constipation
loss of taste/smell	vomiting	weight gain	diarrhea
hot flashes	numb extremities	insomnia	depression
night sweats	low WBC counts	excessive sleepiness	anxiety
headaches	low RBC counts	poor short-term memory	mood swings
edema (swelling limbs)	low platelet counts	mental confusion/fogginess	infection(s)

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 had 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 additional 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!