Intake Questionnaire for Cancer Clients

Name: _____ Referred by: _____

Spouse / Family Caregiver: _____ Relation to Client: _____

Address: _____

City/State/Zip/Country: _____

Cell phone: _____ Home phone: _____

eMail: _____ Skype ID: _____

Blood Type (ABO): _____ Gender: _____ Best way to reach me: [ ] cell [ ] home [ ] email

Date of Birth: _____ Weight now: _____ Usual weight (*if different*): _____ Height: _____

Waist Measurement (*at narrowest area*): _____ Hip Measurement (*at widest area*): _____

Cancer Type / Stage (I-IV): _____ Date of diagnosis: _____

Any metastasis? Where: _____ Known cancer genes: _____

MEDICAL TREATMENTS (*Please do not send medical records*)

Tell us about your treatment history so far… (surgeries, chemotherapy, radiation, clinical trials)

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

Based on your most recent oncology exams—MRI, CT, PET Scan or cancer markers—is your cancer stable, shrinking, or progressing? Do you have a recurrence? Are you in remission?

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 ECOG Performance Status? [Ask your doctor or rate yourself] _____

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 indicate any of the following symptoms you are ***currently experiencing***.

[ ] 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
[ ] recurring infections	[ ] low RBC counts	[ ] poor short-term memory	[ ] mood swings
[ ] lymphedema	[ ] low platelet count	[ ] loss of peripheral vision	[ ] double vision
[ ] cognitive changes	[ ] speech difficulties	[ ] brain fog, forgetfulness	[ ] headaches

OTHER (*please list*): _____

HEALTH HISTORY

[**P**] Enter "**P**" if you've had this condition in the **past** *but no longer experience it*.
[**C**] Enter "**C**" if you **currently** have the condition.

[ ] pneumonia	[ ] tuberculosis	[ ] hepatitis	[ ] jaundice
[ ] diabetes	[ ] hypoglycemia	[ ] kidney stones	[ ] kidney disease
[ ] skin boils	[ ] hives	[ ] eczema/psoriasis	[ ] dental/gum disease
[ ] anemia	[ ] osteoarthritis	[ ] rheumatoid arthritis	[ ] asthma / COPD
[ ] drug reaction	[ ] migraines	[ ] stroke / TIAs	[ ] gout
[ ] low blood pressure	[ ] obesity	[ ] heart disease/attack	[ ] cancer (other)
[ ] high blood pressure	[ ] high cholesterol	[ ] high triglycerides	[ ] fungal infection
[ ] blood transfusion	[ ] candida	[ ] parasite infection	[ ] herpes infection
[ ] brain injury	[ ] chicken pox	[ ] shingles	[ ] bladder infections
[ ] epilepsy/seizures	[ ] autoimmune condition (*please list*): _____		

OTHER surgeries, illnesses, injuries (*please list*): _____

_____

Do you have any drug allergies? [ ] NO [ ] YES (*please list*): _____

Have you ever had any other adverse reactions to drugs or supplements? [ ] NO [ ] YES (*please specify*):

_____

DIET AND LIFESTYLE

Do you adhere to a particular diet? *Check all that apply*.

[ ] Vegetarian [ ] Low-fat diet [ ] Organic

[ ] Vegan [ ] Low-carb diet [ ] Paleo / Primal / Whole-9

[ ] Kosher [ ] Raw foods diet [ ] Ketogenic diet

[ ] SCD or GAPS diet OTHER: _____

Do you consume alcohol? Amounts? How often? _____

Do you experience digestive difficulties? [ ] NO [ ] YES - *Check all that apply*.

[ ] burping or belching [ ] flatulence (gas/wind) [ ] undigested food particles in stools

[ ] bloating [ ] loss of energy 1-2 hrs after eating [ ] acid reflux / GERD

[ ] constipation [ ] diarrhea [ ] poor appetite

Are there particular foods (or food groups) that upset your digestion?

[ ] fats / fried foods [ ] lactose / milk / dairy [ ] beans / legumes

[ ] beans / legumes [ ] fructose / fruits [ ] cabbage / cruciferous vegetables

[ ] gluten / grains [ ] high-fiber foods / FODMAPS [ ] raw vegetables

OTHER: _____

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

History of intestinal disturbances? [ ] NO [ ] YES - *Check all that apply*.

[ ] Celiac disease [ ] Ulcerative colitis [ ] Irritable bowel (IBD or IBS)

[ ] Crohn's disease [ ] Intestinal polyps OTHER: _____

When / how often have you had to take antibiotics? _____

_____

Are you very sensitive to chemicals—perfumes, exhaust fumes, strong odors? [ ] NO [ ] YES (*specify*)

_____

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 is your typical bed time? _____

What are your goals for your health? What are your plans for meeting those goals?

Please attach a photo of yourself (pre- or post-diagnosis), which helps us get to know you better.

eMail we should send updates and new research to? _____

Is there any additional information you would like to share with us?

Nutritional Solutions

Jeanne M. Wallace, PhD, CNC
Michelle Gerencser, MS

(435) 563-0053
Fax (435) 538-8058
www.nutritional-solutions.net
admin@nutritional-solutions.net

DIET SELF-EVALUATION WORKSHEET

This worksheet can help you assess the anticancer power of your diet so you can see your strengths and identify areas that need improvement. For each item, circle the response that most closely matches your typical intake. You may wish to write down everything you eat for one week, then refer to your food journal to help you complete this form most accurately. Study your written report for detailed guidelines on improving your diet. We can help you set specific goals and suggest simple strategies to help you reach them. You can take this self-evaluation again in the future to monitor your progress!

Name: _____ Date(s): _____

	Areas to Improve		Keep up the good work!	
	Yipes!	**A good start**	**Better**	**Awesome**
HEALTH BUILDERS (*emphasize these*)				
Fruits & Vegetables, ½ cup servings	0-3 servings/day	4-5 servings/day	6-7 serving/day	≥ 8 servings/day
How many rainbow colors?	≤ 1 color/day	2 colors/day	3-4 colors/day	≥ 5 colors/day
Crucifers: broccoli, broccoli sprouts, cabbage, kale, Brussels sprouts, cauliflower, arugula, collards, turnips, bok choi, watercress, radish, wasabi	< 1x/week	1-2x/week	3-6x/week	≥ 1-2x/day
Berries, fresh or frozen, ½ cup serving	< 1x/week	1-3x/week	4-6x/week	≥ 1x/day
Carotene family (red/yellow/orange)	< 1x/day	1x/day	2x/day	≥ 3x/day
Lycopene (tomato paste, sauce, soup, juice, salsa)	< 1x/week	1-2x/week	3-6x/week	≥ 1x/day
Dark leafy greens: spinach, chard, kale, collards, romaine lettuce, mesclun baby salad greens	< 1x/week	1-3x/week	4-6x/week	≥ 1x/day
Legumes (beans) and traditional soy foods: miso, tempeh, tofu, edamame	< 1x/week	1-2x/week	3-6x/week	1-2x/day
Organic Foods	none	sometimes	mostly	nearly all
Garlic, onions, leeks, chives, shallots	none or rarely	occasionally	1x/day	≥ 2x/day
Spices: ginger, curry, basil, mint, parsley, rosemary...	none or rarely	1x/day	2x/day	≥ 3x/day
Green Tea	none	1 cup most days	1-2 cups/day	2-3 cups/day
Omega-3 Fats: cold-water fish, grass-fed meat & poultry, free-range eggs, flaxseeds	< 1x/week	1-2x/week	≥ 3-6x/week	≥ 1 serving/day
Other healthy fats: olive oil, avocados, coconut oil, pasture-raised lard, ghee/butter, tallow	none or rarely	occasionally	1x/day	2x/day
HEALTH DETRACTORS (*limit or avoid these*)				
Starches: bread, cereal, pasta, potatoes, grains	≥ 7 servings/day	5-6 servings/day	3-4 servings/day	1-2 servings/day
Sugar, candy, sweets, fruit juices, sodas	≥ 1x/day	3-6x/week	≤ 1-2x/week	rarely or none
Fast food, junk food, processed snacks	≥ 1x/week	1-3x/month	rarely	none
Partially hydrogenated fats, fried foods, margarine	daily	weekly or monthly	rarely	none
Unhealthy fats: soy, corn or vegetable oils; grain-fed meat or poultry, conventional eggs/butter, mayonnaise	≥ 2 serving/day	1 serving/day	infrequently	rarely or none
Alcoholic beverages	≥ 6 servings/week	4-5 servings/wk	1-3 servings/wk	rarely or none
Food additives, preservatives, artificial sweeteners	daily	weekly or monthly	rarely	none

Drug-Nutrient Interaction Worksheet

Name: _____ Date: _____

1 List all prescription and over-the-counter medications in this column	2 During your consultation, we will explore together which natural agents may be a concern for you.				
	A Altered Absorption	**B** Metabolic Interactions	**C** Side Effect Exacerbation	**D** Blood Thinning	**E** Interference with Mechanism of Action

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Increased:
Bromelain
Enzymes

Decreased:
Calcium
Fiber
Flaxseed
Magnesium
Triphala
Zinc

3A4:
Andrographis
Artemisia
Baikal
Bloodroot
Bioflavanoids
Caffeine
Cat's Claw
Chamomile
Cranberry
Curcumin
Dan shen
Echinacea
Genistein
Ginkgo biloba
Goldenseal
Grapefruit
Green tea
Hops
Licorice
Oregano
Pomegranate
Pycnogenol
Quercetin
Resveratrol
Rhodiola
Schizandra
Skullcap
Soy isoflavones
St. John's wort
Turmeric
Valerian

2D6:
Curcumin
Yohimbe

2C9:
Limonene
Melatonin
Milk Thistle
Quercetin

Diarrhea:
Fish oil
Magnesium
Vitamin C

Constipation:
Calcium
Iron

Sun Sensitivity:
Angelica
Dill, fennel, parsley
Kava
St. John's wort
Yarrow

Depending on Dose:
Cayenne
Curcumin
Feverfew
Fish oil
Garlic
Ginger
Ginkgo
Ginseng
Mushrooms
Resveratrol
Vitamin E

NOTE: This worksheet presents both known (well documented) and hypothetical interactions. It is not a complete list of possible interactions, including only supplements frequently used by our clients. Many interactions are dependent upon dosing and timing. During our consultation, we'll help you identify concerns relevant for your situation. Find out which nutrients your medicines deplete online HERE.

CONSENT FORM for NUTRITION CONSULTING

I am enrolling in the educational and consulting services of Nutritional Solutions so I can learn about health factors within my control: my diet, nutrition, and lifestyle choices. By optimizing these factors, I believe I can nourish my health and well-being.

I understand that the consultants at Nutritional Solutions [Jeanne M. Wallace, PhD, CNC and Michelle Gerencser, MS] are not medical physicians or health care practitioners. They do not dispense medical advice nor prescribe treatment. I understand these services are not a substitute for medical care and are not intended to diagnose, treat, alleviate, or care for disease.

Methods of nutritional evaluation or testing made available to me are not intended to diagnose disease. Rather, these assessments serve as a guide to help me develop an appropriate nutrition program tailored to my individual needs, and also help me monitor my progress in achieving my health goals.

Personal information supplied to Nutritional Solutions will be kept strictly confidential (unless I consent to sharing it).

Furthermore, I agree that all of the information I receive from Nutritional Solutions is for the sole use of me, my immediate family and my healthcare team; and that no part of this information may be reproduced, stored in or introduced into a retrieval system, or transmitted, in any form or by any means (electronic, mechanical, photocopying, recording or otherwise) without the prior written permission of Nutritional Solutions. I also agree that I will not participate in or encourage electronic piracy of copyrightable materials.

This form is a release of potential liability. I agree to hold Nutritional Solutions and its employees harmless for claims or damages in connection with our work together.

My signature below confirms I have read, fully understand, and agree to all the above statements and agreements.

Agreements

In the statements below, "you" refers to Nutritional Solutions, its informational products, and employees.

- *I understand you will not give me a meal plan to follow.* I prefer to be taught how to develop healthier dietary practices for myself, so that I'll know how to choose foods for an optimal anti-cancer diet based on my own food preferences.
- *I understand you do not prescribe nutritional supplements, and will not tell me what supplements to take.* I expect you to present me with evidence-based information (about nutritional practices, supplements and herbs). I understand it is my responsibility to decide for myself which diet practices and/or supplements I wish to implement.
- *I understand that you do not provide alternative treatment nor instruction on how to self-treat.* I am enrolling in your services to learn about nutritional strategies that research suggests may (1) bolster the body's innate healing capacity after a cancer diagnosis and/or (2) complement my medical treatments.
- *When communicating with my medical team, insurance company or other people, I will not misrepresent Dr. Wallace or her staff as medical doctors nor as providing treatment, prescribing or diagnosing.*
- *I accept full responsibility for deciding what foods and supplements I put in my body.*

If your expectations do not match the above, perhaps your needs would be better served by a naturopath or alternative medical practitioner. You may wish to call us for a referral.

Signature _____ **Date** _____

My eSignature is legally binding.

Print Name _____ **Relation to client** _____

REQUEST FOR CONSULTING SERVICES

See our website for a complete description of what's included with each program.

[ ] Harnessing the Power of Your Diet Against Cancer **$375**

INCLUDES case review, a packet of program materials mailed to you, and 90 minutes of one-on-one consulting time to develop your individualized diet and nutrition plan and answer your questions.

[ ] ADD-ON **Complementing Radiation** program materials **$125**

[ ] ADD-ON **Complementing Chemotherapy** program materials **$65**

[ ] Complementing Radiotherapy Program **$325**

INCLUDES case review, a packet of program materials mailed to you, Side Effects Handbook, access to the Hotline, and 90 minutes of one-on-one consulting time to review strategies to complement your radiation treatments.

[ ] Complementing Chemotherapy and Biologic Treatments **$325**

INCLUDES case review, Chemo Sheets, Side Effects Handbook, access to the hotline, and 90 minutes of one-on-one consulting to review drug-nutrient interactions and strategies to complement your cancer treatments.

[ ] Shipping within the U.S. (USPS Priority Mail) ..... **FREE**

[ ] International Shipping (USPS Global Express shipping) $45-65, depending on destination ..... **TBD**

Ship my program materials to:

_____

_____

TOTAL

$

Follow-Up Consultations: On-Going Support ..... as needed - **$195/hr**

Each of our programs includes 90 minutes of pre-paid consulting time. This can be used in one long appointment, or several shorter sessions. After this time, follow-up consulting is charged to your credit card on file, billed in 5-minute increments after a 15-minute minimum.

Hotline for Treatment-Related Side Effects ..... as needed - **$65 for 20 min**

No Appointment Needed: Our Hotline is available Monday-Friday, 11:00 AM - 12:00 noon, Mountain Time, for targeted assistance with treatment-related side effects or other symptoms. Access to the hotline is included with all the programs above. It can also be purchased as a stand-alone service. These brief consults, typically 20 minutes long, are billed in 5-minute increments after a 15-minute minimum at our standard rate ($195/hr).

PAYMENT ARRANGEMENTS

Payment Method: [ ] Visa [ ] MasterCard [ ] AmEx [ ] Discover [ ] Check Enclosed

Name on Card _____ Expiration Date* _____

Card Number* _____ 3 or 4-digit Security Code _____

Authorized signature _____ Cardholder's Zipcode _____

*For security, mark the last 4 digits of your credit card "XXXX" and provide that info and the expiration date via email or phone.
Please note: consulting fees are non-refundable.
While advance payment is required, you may be able to obtain insurance reimbursement. Ask your physician for a referral for nutrition consulting (with your ICD-9/10 diagnosis code listed), then submit the referral and your receipt to your insurer.

Return your completed intake forms and a photo of yourself to admin@nutritional-solutions.net or FAX: (435) 538-8058 or MAIL: Nutritional Solutions, 1697 East 3450 North, North Logan UT 84341