

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)

<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 (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, Aromasin, 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 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	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	[] diphtheria	[] 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!