Tri-Life Health, PC

Cancer Patient Intake Questionnaire

General Information

Name _____ Date of Birth _____ Age____ Sex _____

Address _____ City/State/Zip _____

Phone _____ Fax _____ Email _____

Occupation / Employer _____ Church / Religion _____

Marital Status: ___single ___married ___divorced ___widowed

Spouse's name _____ Ages of children _____

Diagnosis

What is your cancer diagnosis?

Stage: □ I □ II □III □ IV □Other

When was it diagnosed? _____ Recurrence: □ Yes □ No
Date: _____

Healthcare Providers

Primary Care Provider: _____
Surgeon: _____
Medical Oncologist: _____
Radiation Oncologist: _____
Other Health Providers: _____

Treatment

What is your current treatment plan? (Including "natural" and "alternative" therapies)

What previous or other treatments have you tried? (i.e., traditional, complementary, natural or alternative treatments)

Treatment (cont.)

Surgery □ Yes □ No
Date: _____Procedure: _____Location: _____

Radiation □ Yes □ No
Date: _____Location: _____

Systemic Therapy (chemo, hormonal, other) □ Yes □ No
Date: _____Agents Used: _____

What methods are being used to track the status / progress of your cancer (for example: MRI scan, blood tests of tumor markers, PSA, CA-125, etc.)?

What is your current diet or nutritional program?

What medical allergies do you have?

Medications

Please list your current medications and supplements: (continue on back of page if necessary)

Current Health and Health History

What other medical conditions do you have?

_____ Heart disease, heart failure
_____ Liver disease, liver problems
_____ Kidney disease, kidney stones
_____ Gout
_____ Thyroid imbalance, low thyroid
_____ Menopause (when _____)
_____ Digestive problems, constipation, irritable bowel, colitis
_____ Infections (please detail: _____)

Do you have a history of?

_____ Dental infections, root canals, gum disease, mercury fillings
_____ Exposure to toxic chemicals, solvents, heavy metals, or other known carcinogens _____
_____ Significant stress, loss, or emotional trauma
_____ Family members / relatives with cancer _____
_____ History of recreational drug use, alcohol or tobacco _____

Patient Values, Priorities and Concerns

What are your goals and expectations for the adjunctive cancer care program?

_____ Improve quality of life
_____ Live longer
_____ Reduce side effects of treatment
_____ Help cure the cancer
_____ Reduce pain
_____ Reduce chance of recurrence
_____ Improve energy, feel better
_____ Improve immune system
_____ Other:

What are your primary concerns and core questions?

What are your sources of strength and inspiration?

What are your sources of emotional and spiritual support?

Do you currently have a support group?