Integrative Cancer Network

Botanical Medicine & Clinical Nutrition

PATIENT INTAKE FORMS

*For Office Use Only

Date of First Appointment _____

Name: _____ Age ____ Date of Birth: _____

Address: _____ City _____State ___ Postcode _____

Mailing Address (if different): _____

Home Phone: _____ Mobile : _____ Work Phone: _____

Fax: _____ E- mail: _____

Support activities/pursuits/groups: _____

Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Living Situation: ☐ Alone ☐ Friend(s) ☐ Partner ☐ Spouse ☐ Parents ☐ Children ☐ Pets: _____

Name of Partner/Spouse:_____

FINANCIAL AGREEMENT

I claim full financial responsibility for services rendered at ICN for _____
CLIENT NAME

and understand that payment is required in full at the time of service.

Signed: _____ Relationship to client: _____

How did you hear about ICN?: _____

Have you ever tried natural medicine or alternative therapies? _____

If so, describe type and frequency:

Therapy	Frequency

Main health concern you wish to address at this time:

CANCER INFORMATION

Have you ever diagnosed with cancer? ☐ Yes ☐ No

When? _____

Location_____

Type?_____

Current Status (eg; post surgery, recurrence, etc.)_____

Current Stage_____

Relevant tumor markers _____

CONVENTIONAL TREATMENT HISTORY

Procedure Date (surgery, chemo, radiation, etc)	Duration

If you are in a clinical trial or experimental protocol please provide details.

CURRENT/RECENT HEALTH CARE PROVIDERS		
Provider Name	Date(s)	Care Provided (surgery, oncology, PCP, etc.)

HOSPITALIZATION(S) [NON-CANCER]			
Date	Hospital/Facility	Diagnosis/Operation	Provider Name

ACCIDENTS/INJURIES (describe briefly)

MORE than 5 years ago _____

LESS than 5 years ago _____

FAMILY HISTORY

Please include any of the following: Alcoholism, high blood pressure, cancer, diabetes, heart- disease, osteoporosis, other addiction or illness.

Member	Living?	Current Age	Important Diseases	Cause of Death	Age at Time of Death
Mother					
Father					
Siblings					
Siblings					
*MGM					
* MGF					
*PGM					
*PGF					

* M = Maternal P = Paternal GM = Grandmother GF = Grandfather

PERSONAL HISTORY

In general, I feel my overall health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Mark the following: 1 - IF CURRENT and 2 - IF PAST

	Asthma		Ringing In Ear		Palpitations		Migraines
	Bronchitis		Sciatic Pain		Tightness In Chest		Frequent Headaches
	Pneumonia		Frequent Urination		Rheumatic Fever		Frequent Depression
	Frequent Colds/Flu		Dribbling Urine		Heart Problems		Jaundice
	Epstein-Barr		Painful Urination		Poor Sleep		Hepatitis
	Chronic Fatigue		Scanty Urination		Hypoglycemia		Hemorrhoids
	Mononucleosis		Blood In Urine		Severe Mood Swings		Eye Problems
	HIV Positive		Prostate Problems		Diabetes		Photophobia
	AIDS		No/Low Sex Drive		Overweight		Dizziness
	Allergies		Impotence/Frigidity		Underweight		Stroke
	Sinus Congestion		Afternoon Persp/Fever		Eating Disorder		Varicose Veins
	Colitis		Night Sweats		Gum/Teeth Problems		Drug Addiction
	Crohns		Hearing Problems		Lots Of Fillings		Alcoholism
	Diverticulitis		Tinnitus		Frequent Frustration		Epilepsy
	Parasites		Memory Difficulty				Frequent Anger
	Gas		Anxiety				Bloating
	Arthritis						

Other:

Height _____ Weight _____ Blood Pressure _____

Skin: ☐ dry ☐ oily ☐ normal

Please rate the following on a scale of 1 to 10: (10 being the best) and write in any comments

Condition	Rating (1 – 10)	Comments
Sleep		
Appetite		
Energy Level		
Digestion		

Any gas, bloating or other discomfort after eating? ☐ Yes ☐ No (Describe:_____)

Stools: ☐ float ☐ sink ☐ daily ☐ bad odor ☐ no odor ☐ blood in stool

Please report how often, and what type/brand, you use any of the following for bowel elimination?

Enemas _____ Laxatives _____ Purgatives _____

How do you feel about the following areas of your life? Please check appropriate boxes & make any comments you would like to make.

	Great	Good	Fair	Poor	Comments
Self					
Work					
Partner					
Sex					
Family					
Diet					
Exercise					

Please rate your stress on a scale of 0 to 10: (10 being the most) and write any comments:

	Yes	No
I worry a great deal		
I feel lonely		
I am bored with my life		
I think a lot about dying		
I have particular concerns relating to my religion		
I feel fearful or afraid		
I fee nervous most of the time		
I often feel depressed		
I feel anxious often		
I am ill frequently		
I sometimes feel weak or light-headed		
I often have pains in my shoulders, neck, and/or back		
I often feel like crying		
I lose my temper more than I used to		

Other personal concerns (please describe):

Please use this space to add any other information about yourself that you think will be of help to us:

DIET AND EXERCISE:

Dietary preferences/restrictions: _____

What is your favorite food? _____ Favorite flavor? _____

Sample of day's menu (Please also fill out 3-day food chart if you have been asked to do so)	
Breakfast	
Lunch	
Dinner	
Snacks	
Drinks/beverage(s)	

Do you exercise regularly? ☐ Yes ☐ No

If yes, what type of exercise do you do? _____ How often? _____

Tobacco use: ☐ Current ☐ Previous
How much?_____ How long? _____

Alcohol use: ☐ Yes ☐ No
How much? _____ How often? _____

Caffeine use: ☐ Yes ☐ No
How much? _____ How often? _____

Other mood altering substances:
Which? _____ Past/Present? _____ How much? _____ How often? _____
Which? _____ Past/Present? _____ How much? _____ How often? _____
Which? _____ Past/Present? _____ How much? _____ How often? _____

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? Please describe:

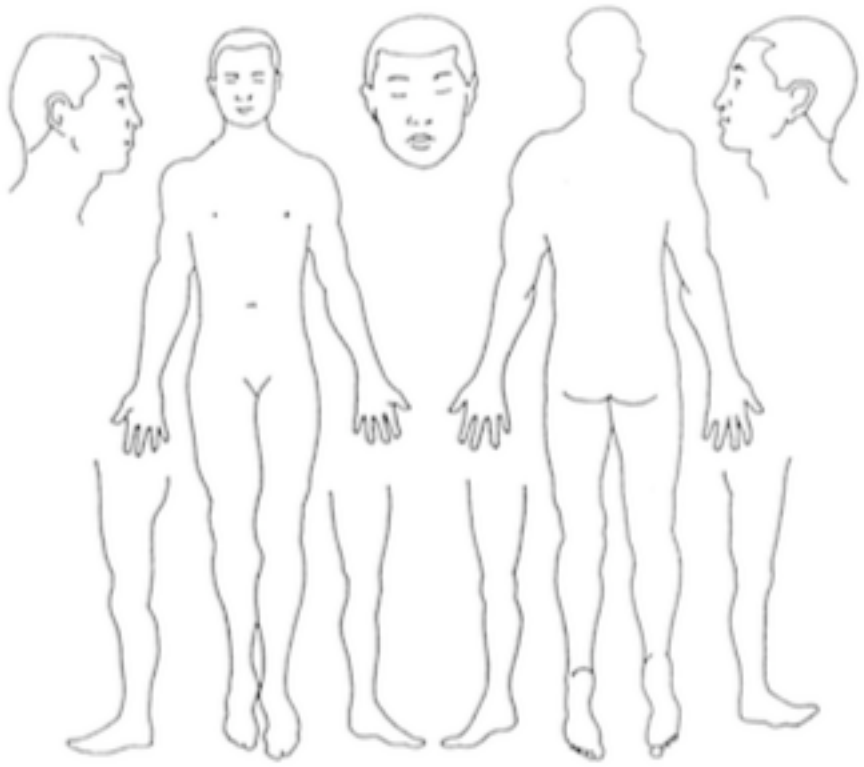
CURRENT DIETARY SUPPLEMENTS AND HERBS (Use separate sheet if necessary)

Agent Name	Brand Name	Potency (mg, IU, etc)	Dose	Frequency

CURRENT PRESCRIPTION MEDICATIONS – Please list all prescription and over-the-counter medications you are currently taking (this should not include chemo and radiation)

Medication	Indication	Duration	Strength	Dose	Frequency

Location of Pain



Area/Description of Symptom(s)/Pain & Frequency	Pain Level 0 to 10 (10 being the highest)

THE QUESTIONS ON THIS PAGE ARE FOR FEMALE PATIENTS ONLY

MENSTRUAL PERIODS – Please complete this section to the best of your ability, even if you no longer menstruate. It provides valuable information for an accurate assessment.

Rjsxywzfynsl xince age: _____
☐ Regular ☐ Light ☐ Heavy ☐ Clots ☐ PMS
Color of blood _____ Menstrual cramps? _____ Which days? _____

Flow lasts how many days? _____ Length of Cycle? _____ Date of last menses _____

Mark the following: 1 – IF CURRENT and 2 – IF PAST

	Hysterectomy		Herpes		Mastectomy
	D & C		Yeast Infections		Lumpectomy
	Tubular Ligation		Interstitial Cystitis		Breast Reconstruction
	Ablation		Infertility		Breast Implants
	Irregular PAP Smear		Pain With Intercourse		Fibroids
	Dryness With Intercourse		Osteoporosis		Irregular Bleeding

Vaginal discharge? ☐ Yes ☐ No
Color _____ Frequency _____ Amount _____

PREGNANCY/BIRTH CONTROL

Are you pregnant now? ☐ Yes ☐ No
Do you think you might be? ☐ Yes ☐ No
Number of pregnancies _____ Number of children_____
Number of terminations? _____ Number Miscarriages? _____
Tubular pregnancies? _____ Difficulty in conceiving? ☐ Yes ☐ No

Birth control method(s) _____

MENOPAUSE

No menses since_____

Experiences/symptoms you are currently feeling/having?

Experiences/symptoms you had in the past during menopause?

Email this form to clinic@integrativecancernetwork.com