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sagecancercare.com

Thank you for taking the time to complete this form. Your answers will greatly assist our doctors in providing you the best care possible. All information is confidential.

Name: ______________________________________Date: ___________Date of Birth: _________

Address: ____

Cell Phone: __________________________________Home Phone: _________________________

Preferred contact number: ☐Cell ☐Home ☐ Other: ____________________________________

Email: ______________________________________Social Security #: ______________________

Emergency Contact Name: ____________________Relationship: __________________________

Emergency Contact Phone: ____

How did you hear about Sage Cancer Care? ____

Sage Cancer Care or individual health care providers will occasionally need to call patients and we wish to ensure your privacy regarding your treatment at our clinic. If we are unable to reach you by phone, please indicate where it is appropriate to leave voice messages for you:

☐ Home answering machine ☐ With family members ☐ At Work ☐ Never leave messages

Is this your first visit to a naturopathic doctor? ☐Yes ☐No

What do you hope to get out of your visit today?

____

____

What are your most important health concerns or symptoms? Please list in order of importance.

1. ____

2. ____

3. ____

4. ____

Cancer Diagnosis and Treatment History

Please fill out this section as accurately as possible. Leave blank any questions that do not apply.

Date of initial diagnosis: ___________________Type of tumor: ____________________________

Current status (check one): ☐ Remission ☐ Active

Cancer treatment history and your health care team:

Surgery type and date: ____

____

Surgeon: _______________________________Phone number: ____________________________

Radiation therapy type and date range: ____

____

Radiation oncologist: _____________________Phone number: ____________________________

Chemotherapy treatment types and date range: ____

____

Medical oncologist: _______________________Phone number: ____________________________

Additional health care providers (including integrative and alternative) working with you:

Primary care: _______________________________ Phone number: _______________________

Name: ____________________________________ Phone number: _______________________

Name: ____________________________________ Phone number: _______________________

Name: ____________________________________ Phone number: _______________________

Do you have a family history of cancer? ☐ Yes ☐ No ☐ Unsure

If yes, please list relationship to you and type of cancer:

Relationship	Type of Cancer

General Health Information

Height: _______Weight: _______Weight 1 year ago: _______Max weight: _______When: ________

Primary interests and hobbies: ____

Primary form of exercise, if any: _________________________________How often: ______________

Allergies

Do you have an allergy to any of the following? List specific allergies and describe your reaction.

Drugs: ____

Foods: ____

Chemicals/Perfumes: ____

Animals: ____

Medications and Supplements

Please list any prescriptions, OTC medications, or supplements that you currently take.

Medication/Supplement Name	Dose	Frequency

(continue on last page if necessary)

Medical History

Do you have a personal history of any of the following conditions (check box if yes)?

☐ Autoimmune ☐ Asthma/COPD ☐ Heart disease ☐ Multiple sclerosis

☐ Anemia ☐ Crohn's/Colitis ☐ Hypertension ☐ Osteoporosis

☐ Anxiety disorder ☐ Depression ☐ IBS ☐ Stroke

☐ Arthritis ☐ Diabetes ☐ Kidney disease ☐ Other (see below)

Please list any other significant medical conditions here:

____

Diet and Lifestyle

24-hour diet recall (please list all food and drink you have had in the past 24 hours):

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Please check "Yes" or "No" for the following questions:

	Yes	No		Yes	No
Get 6-8 hours of sleep nightly?			Drink alcohol?		
Sleep well?			Use tobacco? Number of packs daily: ________ Number of years: _____________		
Wake feeling rested?			Enjoy your work?		
In a supportive relationship?			Take vacations?		
History of abuse?			Spend time outside?		
Major life trauma (past 3 years)?			Eat 3 meals daily?		
Use recreational drugs?			Drink soda/cola regularly?		

Assessing the Areas of Your Life

In assessing your health, it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. For each category below, please rate your satisfaction on a scale of 1 to 10, with 10 being completely satisfied (check appropriate number for each category).

	0	1	2	3	4	5	6	7	8	9	10
Friends and Family											
Living Environment											
Health											
Career											
Relationships/Romance											
Recreation											
Money											
Personal Growth/Spirituality											

Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past 6 months. Some are yes/no questions, in which case check the box to indicate "yes."

Mental/Emotional	
Depression	
Treated for depression	
Poor concentration	
Mood swings	
Anxiety or nervousness	
Tension	
Memory problems	
Endocrine	
General fatigue	
Heat intolerance	
Cold intolerance	
Excessive hunger	
Seasonal depression	
Immune	
Ongoing infections	
Slow wound healing	
Colds/flu more than once yearly	
Swollen glands	
Neurological	
Seizures	
Muscle weakness	
Loss of memory	
Vertigo/Dizziness	
Easily stressed	
Numbness or tingling	
Involuntary shaking of hands	

Head/ENT	
Headaches	
Migraines	
Stuffiness/Nasal congestion	
Sinus pain	
Nose bleeds	
Change in smell	
Eye pain/strain	
Uncomfortable tearing or dryness	
Blurriness	
Double vision	
Frequent popping of the ears	
Ringing in the ears	
Sore tongue/lips	
Teeth grinding	
Gum bleeding/pain/disease	
Dental cavities	
Excessive saliva	
Frequent sore throat	
Hoarseness	
Lumps on neck	
Goiter/enlargement in front of throat	
Neck pain or stiffness	
Blood/Peripheral Vascular	
Easy bleeding/bruising	
Deep leg pain	
Anemia	

Respiratory	
Cough	
Spitting up blood	
Bronchitis	
Pneumonia	
Emphysema	
Pain on breathing	
Shortness of breath	
Lung congestion/sputum	
Wheezing	
Difficulty breathing	
Difficulty taking a deep breath	
Gastrointestinal	
Difficulty swallowing	
Change in thirst	
Change in appetite	
Nausea/vomiting	
Burning pain in stomach	
Jaundice	
Gallbladder disease	
Liver disease	
Hemorrhoids	
Acid reflux/Heartburn	
Abdominal pain or cramps	
Excessive belching or excess gas	
Constipation	
Diarrhea	
Black stools	
Blood in stools	
Undigested food in stools	
Daily bowel movement	

Cardiovascular	
High blood pressure	
Low blood pressure	
Blood clots	
Rheumatic fever	
Ankle swelling	
Angina/chest pain	
Heart murmurs	
Fainting	
Heart palpitations/fluttering	
Skin	
Rashes/Acne	
Lumps	
Eczema	
Hives	
Generalized itching	
Night sweats	
Musculoskeletal	
Joint pain or stiffness	
Muscle spasms or cramps	
Nerve pain	
Urinary	
Pain with urination	
Frequency at night	
Frequent infections	
Unable to hold urine	
Kidney stones	
Male Reproductive	
Hernias	
Prostate disease	
Sexually active	

Female Reproductive	
Age at first menses (first period): _________	
Age of last menses (if menopausal): _______	
Usual length of menstrual cycle: __________	
Duration of menses (days of bleeding):____	
Irregular cycles	
Painful menses	
Heavy flow	
Light flow	
Bleeding/spotting between periods	
Clotting	
Vaginal discharge	
PMS	

Menopausal symptoms	
Endometriosis	
Ovarian cysts	
Date of last annual exam/Pap:	
History of abnormal pap smear	
Sexually active	
Pain during intercourse	
Regular self-breast exams	
Breast pain or tenderness	
Breast lumps	
Nipple discharge	
Number of pregnancies: ________________	
Number of live pregnancies: _____________	

Do you have any other health concerns that have not been covered in this questionnaire?

____

____

____

Consent to Treatment

Naturopathic and Chinese Medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, bruising, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed, the risks, and the alternative treatments available.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

____ ____________________

Signature Date