



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 \_\_\_\_\_

<u>FAMILY HISTORY</u>					
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

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

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 feel 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:





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.

First menstruation since 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?