Integrative Oncology Intake Form

(Please Fill Out the Blanks)

Personal Information: Date:

First Name: Middle Name: Last Name:

What name would you like to be called? Date of Birth: Age:

Preferred Contact Number:

Email Address:

Person to Contact in Case of an Emergency:

Phone #:

Dr. Referred me: Dr. Ortiz Other:

Health Care Team

Medical Oncologist:

Radiation Oncologist:

Primary Care Doctor:

Surgeon:

Social Worker/Psychologist:

Alternative Practitioner:

Cancer Diagnosis Information

Date of Diagnosis: Type of Cancer:

Stage: Treatment: Recurrence: Yes or No

Persistent Effects of Treatment/Continuing Signs Symptoms

List Any Persistent Effects of Treatment: Ex. Neuropathy, Menopause, Memory Problems etc.

What prior experiences have you had with alternative or complementary medicine?

Is there anything else that you feel may be important for us to know?

Goals for Visit: What do you hope to achieve from your visit today?

Supplements: List all the vitamins, minerals, herbal medicines, and other nutritional supplements that you are taking

Vitamin/Mineral/Supplement Name	Dosage	Date Started	Reason

Prescription Medication: What medications are you taking? Include non-prescription drug: Ex: Tylenol or Ibuprofen

Medication Name	Dosage	Date Started	Reason

Allergies: Do you have Medication Allergies: Yes or No

If yes, list all allergies to Medicines/Supplements/Foods

Medication/ Supplements/ Food	Reaction

Personal Medical History

Current Medical Problems: Ex. Diabetes, Heart Disease, High Blood Pressure, Thyroid Disease

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Past Medical History

List Any Major Illnesses, Hospitalizations – include year if known

	Year
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Past Surgical History

List Any past Surgeries

	Year
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Family History

Family Member	Condition	Age of Diagnosis	Treatment/Status	Living/Deceased

REPRODUCTIVE HISTORY

Number of Pregnancies: Live Births: Abortions: Miscarriages:

Date of Last Menstrual Period:

SEXUAL HISTORY

Are you currently sexually active? Yes or No

Are you satisfied with your sex life? Yes or No

SOCIAL HISTORY

Occupation (current or past) :

Are you currently working? Yes or No If so, how many hours a week?

Support System

Do you have a support system? Yes or No If yes, describe:

- With whom do you live **(include roommates, friends, partners, spouse, children, parents, relatives, pets) ?**

HABITS

TOBACCO USE

Do you currently use tobacco? Yes or No

Are you frequently around people who smoked? Yes or No

Have you ever smoked? Yes or No Year Quit: Numbers of years of use: Amount per day:

ALCOHOL USE

Do you drink alcohol? Yes or No If so, how many drinks a week?

DRUG USE

Have you ever used recreational drugs? Yes or No If yes, explain:

HEALTH HABITS

Nutritional History

Do you eat a healthy diet? Yes or No

How many servings of caffeine do you drink a day?

How many ounces of water do you drink a day?

How many ounces of soda do you drink a day?

How many servings of fruits and veggies do you eats in a day?

How many servings of red meat do you eat in a week?

Do you avoid any certain foods?

STRESS

What is your current stress level?

None 0 | 1 | 2 | 3 | 4 | 5 | 6 |7 | 8 | 9 |10 Worst Possible

What do you do to relax/relieve stress?

SLEEP PATTERN

How many hours of sleep do you get in a night?

Is your sleep restful? Yes or No If no, explain:

PHYSICAL ACTIVITY OR EXERCISE

Do you exercise regularly? Yes or No

If so, what type and how often:

SPIRITUALITY

Do you believe in a higher power? Yes or No

Do you have a spiritual practice? Yes or No If so, describe:

CURRENT STATE OF HEALTH

Pick the number that best describes how you feel now:

Nausea: None 0 | 1 | 2 | 3 | 4 | 5 | 6 |7 | 8 | 9 |10 Worst Possible

Pain: None 0 | 1 | 2 | 3 | 4 | 5 | 6 |7 | 8 | 9 |10 Worst Possible

Tiredness – decreased energy: None 0 | 1 | 2 | 3 | 4 | 5 | 6 |7 | 8 | 9 |10 Worst Possible

Well-being - overall comfort: None 0 | 1 | 2 | 3 | 4 | 5 | 6 |7 | 8 | 9 |10 Worst Possible

Anxiety: None 0 | 1 | 2 | 3 | 4 | 5 | 6 |7 | 8 | 9 |10 Worst Possible

Depression – sad or blue: None 0 | 1 | 2 | 3 | 4 | 5 | 6 |7 | 8 | 9 |10 Worst Possible

Shortness of Breath: None 0 | 1 | 2 | 3 | 4 | 5 | 6 |7 | 8 | 9 |10 Worst Possible

Appetite: None 0 | 1 | 2 | 3 | 4 | 5 | 6 |7 | 8 | 9 |10 Worst Possible