



*Seeds of Health Acupuncture, LLC*

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## Complementary Cancer Care Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Your Typical Weight: \_\_\_\_\_

Oncologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

The year of your first cancer diagnosis: \_\_\_\_\_ Type: \_\_\_\_\_

Date of any recurrence: \_\_\_\_\_ Type(s): \_\_\_\_\_

Have you had surgery for cancer? \_\_\_\_\_ When? \_\_\_\_\_

Have you had reconstructive surgery? \_\_\_\_\_ When? \_\_\_\_\_

Are you currently undergoing Chemo? \_\_\_\_\_ Radiation? \_\_\_\_\_

Do you currently have any Ports? \_\_\_\_\_ Expanders? \_\_\_\_\_

Do you have any of these associated symptoms? \_\_\_\_\_ Since when? \_\_\_\_\_

\_\_\_\_\_ Fatigue \_\_\_\_\_

\_\_\_\_\_ Pain \_\_\_\_\_

\_\_\_\_\_ Low Appetite \_\_\_\_\_

\_\_\_\_\_ Constipation/Diarrhea \_\_\_\_\_

\_\_\_\_\_ Nausea \_\_\_\_\_

\_\_\_\_\_ other: \_\_\_\_\_

\_\_\_\_\_ other: \_\_\_\_\_

Do you have low white blood cell count or anemia? \_\_\_\_\_

Do you have other unrelated conditions or diagnoses? \_\_\_\_\_

Is there anything else, cancer-related or otherwise, that you would like me to know? \_\_\_\_\_

\_\_\_\_\_

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