Maple Tree CANCER ALLIANCE

CLIENT PROFILE AND HEALTH HISTORY

Name: _____ Age: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Cell Phone: _____ Home or Work Phone: _____

Profession: _____ Referred by: ❑ Website ❑ Other: _____

Emergency Contact: _____ Phone: _____

PRE-EXISTING CONDITIONS *(Check all spaces below which apply to you.)*

Yes	Condition	Explain and Date
	High Blood Pressure	
	Chest Discomfort	
	Neuropathy	
	Lung Disease	
	Stomach or Intestinal Problems	
	Anemia	
	Stroke	
	Migraine	
	Dizziness or Fainting Spells	
	Leg Pain	
	Back/Neck Pain	
	Lymphedema	
	High Cholesterol	
	Diabetes	
	Thyroid Problems	
	Respiratory Problems	
	Fatigue	
	Arthritis	
	Epilepsy	
	Anxiety/Depression	

CLIENT PROFILE AND HEALTH HISTORY

Type of Cancer: _____ Date of Diagnosis: _____

Specific Location: _____ Type of Surgery: _____

Operations: (Start with most recent)

1. _____

2. _____

3. _____

4. _____

Post-Surgery Treatment (Chemotherapy/Radiation): _____

Type of Chemotherapy(s) (Please List All): _____

_____

Lymph Nodes Removed: ❑ Yes ❑ No If yes how many, and where from: _____

What is Your Treatment Schedule? Any Complications? _____

_____

_____

Medications: (List all current medications)

Medication Dose Date Started

_____

_____

_____

_____

_____

Drug Allergies: _____

Are you currently active in an exercise program? Please Describe: _____

_____

How many days/week do you exercise regularly? _____ How many hours? _____

Is your exercise: ❑ Light ❑ Moderate ❑ Vigorous

What physical activities are most enjoyable to you: _____

_____

_____