LIVING WELL WITH CANCER

New Client Assessment Form

Name: ______________________________

Address: ______________________________

Home or Mobile Phone: ______________________________

Best (*preferred*) Time to Reach You: ______________________________

Email Address: ______________________________

Identified Gender: ______________________________

What is your cancer diagnosis? ______________________________

When were you diagnosed? ______________________________

Are you currently in treatment? If so, what type of treatment - surgery, chemo, radiation, biologics)

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If you are a caregiver of someone with cancer, what is your relationship to the patient? ______________________________

At the present time, do you have people you feel are supportive of your needs?

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Have you worked with any complementary therapies? If so, which ones:

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Are you being treated for other medical conditions?

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What medications/supplements do you take?

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What would you like to achieve by the end of this program?

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