# Integrative Intake

## Reason for Seeking Integrative Oncology Consultation

1. Reason for seeking integrative oncology consultation.

☐Symptoms ☐Supplement review ☐Lifestyle

1a. I am having symptoms I would like help with:

☐Having side e!ects from aromatase inhibitor
☐Fatigue
☐Menopausal symptoms (hot flashes, low sex drive, vaginal dryness, all of these)
☐Nerve damage from chemotherapy
☐Other symptoms _____

1b. I would like to discuss supplements I am taking:

1c. I would like to talk about lifestyle approaches for feeling better and dealing with cancer. F Nutrition

☐Physical activity
☐Stress management
☐Getting better sleep
☐Other _____

2. Out of all of your concerns/questions, what is the top concern or question you would like to discuss at your visit?

3. What medications are you currently taking?
Name, amount, and how many times a day.

4. What current supplements, vitamins, herbs, powders, or other over the counter products are you currently taking?
Please provide brand when possible, amount, and how often you are taking them.

5. Are you currently using or have you ever used any complementary alternative or integrative modalities?

☐Yes ☐No

## 6. Nutrition

6a. Have you had any recent weight gain or weight loss?
☐Yes ☐No

6b. On an average day how many servings of fruits do you have?
☐0 ☐1 ☐2 ☐3 ☐4 ☐>/= 5

6c. On an average day how many servings of vegetables do you have?
☐0 ☐1 ☐2 ☐3 ☐4 ☐>/= 5

6d. In an average week how many times do you eat seafood?
☐0 ☐1 ☐2 ☐3 ☐4 ☐>/= 5

### Weekday Eating Habits

Please answer questions 6e-6h based on your average weekday eating habits.

6e. What do you eat for breakfast?

6f. What do you eat for lunch?

6g. What do you eat for dinner?

6h. What do you eat for snacks?
Please include what you eat and time you eat.

### Weekend Eating Habits

Please answer questions 6i-6l based on your average weekend eating habits.

6i. What do you eat for breakfast?

6j. What do you eat for lunch?

6k. What do you eat for dinner?

6l. What do you eat for snacks?
Please include what you eat and time you eat.

### Weekday Drinking Habits
Please answer questions 6m-6o based on your average weekday drinking habits.

6m. Ca!einated Beverages? What and how much?

6n. Alcoholic Beverages? What and how much?

6o. Other Drinks? Sodas, juice, herbal teas, water, etc.

### Weekend Drinking Habits
Please answer questions 6p-6r based on your average weekend drinking habits.

6p. Ca!einated Beverages? What and how much?

6q. Alcoholic Beverages? What and how much?

6r. Other Drinks? Sodas, juice, herbal teas, water, etc.

6s. Do you have any nutrition goals or interests you would like us to be aware of?

## 7. Exercise/Physical Activity

7a. Do you have an exercise routine?
☐ Yes ☐ No

7b. What exercise equipment do you have at home?

7c. Do you have injuries or disabilities that limit your activity?

7d. Do you have any activity goals or interests you would like us to be aware of?

## 8. Stress Management/Social Support

8a. Do you have a spiritual practice or spiritual community that you rely on? If so please provide details.

8b. Do you practice any stress management techniques such as meditation, journaling, breathing exercises, prayer or others?
☐Yes ☐No

8c. Do you have any regular hobbies or creative activities that you engage in?

8d. Do you belong to any clubs or social groups that you regularly participate in?

8e. Are you currently in a relationship?
☐Yes ☐No ☐Would rather not say

8f. Are you currently sexually active?
☐Yes ☐No ☐Would rather not say

8g. Who do you live with?

8h. Do you have a pet?

8i. Do you feel safe at home and at work?
☐Yes ☐No ☐Would rather not say

8j. Do you have a history of trauma?
☐Yes ☐No ☐Would rather not say

8k. Do you have any loss/grief we should be aware of?

8l. Do you have any stress management goals or interests you would like us to be aware of?

## 9. Sleep

9a. Do you generally feel well rested during the day?
☐Yes ☐No

9b. Do you have daytime sleepiness?
☐Yes ☐No

9c. If you are sitting on the couch at noon would you fall asleep?
☐Yes ☐No

9d. How many hours of sleep do you get most nights?

9e. Do you generally go to bed at the same time every night? What time?
☐Yes ☐No Time:

## 10. Nicotine Exposure

10a. Please include in question 10a any past and current nicotine exposure to: Smoking cigarettes or cigars, chewing tobacco, vape, or secondhand exposure.

10b. If you currently are using Nicotine are you interested in quitting?
☐Yes ☐No

11. Do you use any marijuana or CBD products?
☐Yes ☐No

12. Is there anything else that you think it is important for us to know?