synergy physio

2332 Scarth Street Regina, Saskatchewan
phone: 306-569-6683 Fax: 306-569-6978

BREAST CANCER CLIENT INFORMATION

Client History

Name: General Information

First:__________ Middle:______ Last:__________
Date of Birth:__________ Age:__________
Address:__________
Street:__________ P.O Box:__________
City:__________ Postal Code:__________
Home#:__________ Work#:__________ Cell#:__________
E-mail:__________

Name of person to contact in an emergency:__________
Home#:__________ Work #:__________ Cell#:__________

Your General Health History

___Heart Disease
___Stroke
___Vision Problems
___Lymphedema
___Anxiety/Depression
___Foot/Ankle Problems
___Shoulder
___ High Blood Pressure
___ Diabetes
___ Respiratory Problems
___ High Cholesterol
___ Back/Neck Problems
___ Knee/Hip Problems
___ Other: __________

Comments:__________

Family Health History

___High Disease
___High Cholesterol
___Diabetes
___Family Member(s):
___ Heart Attacks
___ Stroke
___ Cancer

____

Have you ever Smoked? __________

Are you currently a smoker? _______ Amount smoked Weekly? ___________

Start Date: _________________________ Quit Date (if applicable): _____________

Sleep

During the past week, what was your average amount of sleep per nights?

____

What was your average amount of sleep on the weekend night?

____

Would you classify your sleep as restful or restless?

____

Do you awake often during the night?_________________________________

Do you take sleep aid regularly?____

Exercise

Do you exercise on a regular basis?_______________________________________

How many days of the week do you exercise regularly?_______________________

What exercise do you regularly participate in?

____

How many minutes of exercise do you do at once?

____

What types of physical activity do you enjoy the most?

____

What type of recreational activities do you enjoy?

____

How has your physical activity changed in the past year?

____

Daily Activities Analysis

Do you have difficulties performing any of the following tasks?

____opening jars/turning doorknobs

____carrying groceries/dishes away

____removing laundry from washer/dryer

____clasping any articles of clothing

____routine yard work

____driving

____making a bed

____lifting children

____other:_______________________

Did the difficulty begin before or after your treatment for cancer?

____

Do you have any joint aches? Yes/No
Do you have any pain in your arm or shoulder? Yes/No
Do you have any swelling in your arm? Yes/No
Do you wear a preventive sleeve for lymphedema? Yes/No
Is it difficult to raise your arm or move it sideways? Yes/No
Have you had pain in the area of your affected breast? Yes/No
Have you felt weak? Yes/No
Have you lacked appetite? Yes/No
Have you felt nauseated? Yes/No
Other
Concerns: ____

____

Medications

Medication: **Dosage:** **Date started**

____

____

____

Allergies Food:____
Allergies Drug:____

Medical Staff

Family Doctor:

____

Surgeon:

____

Oncologist:

____

Radiation Oncologist:

____

Physical Therapist:

____

Currently working? Yes/No
Occupation:____
Rate your occupation:
____inactive (desk job)

____light work (housework, light carpentry)
____heavy work (construction, lifting)

Cancer Diagnosis: ____

Surgery
Have you had a surgery:__________
If yes please provide dates and details (write answer below)
____
____
____

Treatment
Start date of treatment: ____
End date of treatment:____
Currently undergoing chemotherapy: Yes ______ No _______
Treatment schedule (frequency, length in week, # of times per week):
____
Currently undergoing radiation:____
Treatment schedule:____
Hormone therapy:____
Start date/End date:____
Concerns or complications:____

Are you attending on an insurance/Disability claim Yes____ No____
If yes:
Company Name____
Claim/Policy #:____
Rep Name:____
Phone :____
E-mail:____