Oncology Rehabilitation
Patient Registration Form

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____

Date of Birth: _____

PATIENT HISTORY

Physician Information

Which doctors (primary care, oncology and/or any other) would you want to receive information about your rehabilitation:

1) _____

2) _____

3) _____

4) _____

History of Present Illness

Date of cancer diagnosis: _____

Type of cancer: _____

Stage of cancer: _____

Treatment for cancer diagnosis (list what you have undergone (previous chemotherapy / radiation / surgeries), are currently undergoing, and what you expect to undergo in the future):

_____

_____

_____

Do you have any other diagnoses pertinent to your condition?

_____

_____

List any problems you are having as a result of cancer treatment:

Current Medications

List all medications including over the counter/supplements/vitamins:

Allergies:

Past Medical History

List any medical conditions you have that you have not already described, e.g., diabetes, high blood pressure, etc:

Past Surgical History

List any surgeries you have had in the past, including the date:

Social/Functional History

Describe your current work status and any limitations you have regarding work:

Describe your current living situation (e.g., who do you live with, what kind of dwelling do you live in, etc.):

Describe any limitations you have in your daily life or recreational activities:

Describe your current exercise regimen and any limitations you have regarding exercise:

Do you consume alcoholic beverages? □ Yes □ No

Do you smoke now or have you in the past? □ Yes □ No

What are your rehabilitation goals?

Review of Systems

Height (feet/inches):

Current weight (pounds):

Weight one year ago (pounds):

Check the box if you have or have ever had any of these problems:

	Frequent fevers		Congestive heart failure		Gout
	Night sweats		Bronchitis/pneumonia		Rashes/eczema/psoriasis
	Unexplained weight loss		Chronic cough		Skin growths/lesions/lumps
	Unexplained weight gain		COPD/emphysema		Difficulty healing
	Insomnia		Snoring or sleep apnea		Fainting/dizziness
	Chronic fatigue		Shortness of breath		Tremors/shakes
	Daytime sleepiness		Nausea/vomiting		Tingling/numbness
	Wear glasses/contacts		Hernia		Muscle weakness
	Double vision		Stomach ulcers		Stroke/paralysis
	Blurred vision		Jaundice/liver disease		Concussion/head injury
	Glaucoma		Hepatitis		Memory problems
	Hearing loss		Irritable bowel syndrome		Personality changes
	Ringing in the ears		Diverticulosis		Headaches
	Balance problems/vertigo		Abdominal pain		Seizures/epilepsy
	Earaches/infections		Frequent urination		Nervousness/anxiety
	Sinus infections		Difficulty/pain urinating		Addiction
	Frequent colds/congestion		Bladder or kidney infection		Depression
	Nosebleeds		Kidney disease		Psychiatric Diagnosis
	Deviated septum		Neck pain		ADD/ADHD
	Frequent sore throats		Mid back pain		Posttraumatic stress
	Mouth ulcers, lumps, lesions		Low back pain		Psychiatric hospitalization
	Loss of taste or smell		Hip/leg/knee/ankle/foot pain		Heat or cold sensitivity
	Persistent hoarseness		Shoulder/arm/elbow/wrist/hand pain		Diabetes
	Difficulty swallowing		Muscle aches/spasms		Thyroid disease
	High blood pressure		Joint swelling/stiffness		Obesity
	Heart murmur		Broken bones		Anemia
	Palpitations/irr. heartbeat		Joint dislocations		Easy bruising
	Leg cramps		Arthritis		Transfusion in the past
	Swelling of feet or ankles		Chest pain		HIV positive/AIDS
	History of blood clots		History of heart attack		

Fatigue Symptoms

Do you have significant fatigue?	Yes	No
Do you have diminished energy?	Yes	No
Do you have an increased need to rest, disproportionate to any recent change in activity level?	Yes	No

Fatigue Visual Analog Scales

FATIGUE SEVERITY (CIRCLE ONLY **ONE** NUMBER PER QUESTION)

A. Rate how severe your fatigue is right now:

0 1 2 3 4 5 6 7 8 9 10
(No fatigue) (Unbearable)

B. Rate how severe your fatigue is on your worst day:

0 1 2 3 4 5 6 7 8 9 10
(No fatigue) (Unbearable)

C. Rate how severe your fatigue is on average:

0 1 2 3 4 5 6 7 8 9 10
(No fatigue) (Unbearable)

FACTIT-F (Version 4)*

Below is a list of statements that other people with your illness have said are important**.**
Please circle or mark **one** number per line to indicate your response as it applies to the past 7 days.

PHYSICAL WELL-BEING

		Not at all	A little bit	Some-what	Quite a bit	Very much
GP1	I have a lack of energy.	0	1	2	3	4
GP2	I have nausea.	0	1	2	3	4
GP3	Because of my physical condition, I have trouble meeting the needs of my family.	0	1	2	3	4
GP4	I have pain.	0	1	2	3	4
GP5	I am bothered by side effects of treatment.	0	1	2	3	4
GP6	I feel ill.	0	1	2	3	4
GP7	I am forced to spend time in bed.	0	1	2	3	4

SOCIAL/FAMILY WELL-BEING

		Not at all	A little bit	Some-what	Quite a bit	Very much
GS1	I feel close to my friends.	0	1	2	3	4
GS2	I get emotional support from my family.	0	1	2	3	4
GS3	I get support from my friends.	0	1	2	3	4
GS4	My family has accepted my illness.	0	1	2	3	4
GS5	I am satisfied with family communication about my illness.	0	1	2	3	4
GS6	I feel close to my partner (or the person who is my main support).	0	1	2	3	4
	Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box □ and go to the next section.					
GS7	I am satisfied with my sex life.	0	1	2	3	4

EMOTIONAL WELL-BEING

		Not at all	A little bit	Some-what	Quite a bit	Very much
GE1	I feel sad.	0	1	2	3	4
GE2	I am satisfied with how I am coping with my illness.	0	1	2	3	4
GE3	I am losing hope in the fight against my illness.	0	1	2	3	4
GE4	I feel nervous.	0	1	2	3	4
GE5	I worry about dying.	0	1	2	3	4
GE6	I worry that my condition will get worse.	0	1	2	3	4

FUNCTIONAL WELL-BEING

		Not at all	A little bit	Some-what	Quite a bit	Very much

GF1	I am able to work (include work at home).	0	1	2	3	4
GF2	My work (include work at home) is fulfilling.	0	1	2	3	4
GF3	I am able to enjoy life.	0	1	2	3	4
GF4	I have accepted my illness.	0	1	2	3	4
GF5	I am sleeping well.	0	1	2	3	4
GF6	I am enjoying the things I usually do for fun.	0	1	2	3	4
GF7	I am content with the quality of my life right now.	0	1	2	3	4

ADDITIONAL CONCERNS

		Not at all	**A little bit**	**Some - what**	**Quite a bit**	**Very much**
HI7	I feel fatigued.	0	1	2	3	4
HI12	I feel weak all over.	0	1	2	3	4
An1	I feel listless (“washed out”).	0	1	2	3	4
An2	I feel tired.	0	1	2	3	4
An3	I have trouble starting things because I am tired.	0	1	2	3	4
An4	I have trouble finishing things because I am tired.	0	1	2	3	4
An5	I have energy.	0	1	2	3	4
An7	I am able to do my usual activities.	0	1	2	3	4
An8	I need to sleep during the day.	0	1	2	3	4
An12	I am too tired to eat.	0	1	2	3	4
An14	I need help doing my usual activities.	0	1	2	3	4

An15	I am frustrated by being too tired to do the things I want to do.	0	1	2	3	4
An16	I have to limit my social activity because I am tired.	0	1	2	3	4

Pain Symptoms

Pain Visual Analog Scales

PAIN SEVERITY (CIRCLE ONLY **ONE** NUMBER PER QUESTION)

A. Rate how severe your pain is right now:

0 1 2 3 4 5 6 7 8 9 10
(No pain) (Unbearable)

B. Rate how severe your pain is on your worst day:

0 1 2 3 4 5 6 7 8 9 10
(No pain) (Unbearable)

C. Rate how severe your pain is on average:

0 1 2 3 4 5 6 7 8 9 10
(No pain) (Unbearable)

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Distress Symptoms

Distress Visual Analog Scales

DISTRESS* SEVERITY (CIRCLE ONLY **ONE** NUMBER PER QUESTION)

* Distress is defined by the National Comprehensive Cancer Network as "a multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment.

A. Rate how severe your distress is right now:

0 1 2 3 4 5 6 7 8 9 10
(No distress) (Unbearable)

B. Rate how severe your distress is on your worst day:

0 1 2 3 4 5 6 7 8 9 10
(No distress) (Unbearable)

C. Rate how severe your distress is on average:

0 1 2 3 4 5 6 7 8 9 10
(No distress) (Unbearable)

Additional information: _____

_____

_____

- Do you have a concern for your safety from someone in your home or community? ☐ Yes ☐ No
- Have you fallen in the past 3 months? ☐ Yes ☐ No
- Do you have a concern that you may fall during daily activities? ☐ Yes ☐ No

Reviewed by Staff: _____ Date: _____

Comments: _____

_____

To the best of my knowledge, the above information is correct:

_____

Patient Signature: Date