

**Cancer Rehabilitation Program New Patient Questionnaire  
A Collaboration of Courage Kenny Rehabilitation Institute,  
Virginia Piper Cancer Institute and Allina Health**

Please bring completed form to your appointment or fax prior to your appointment to 612-863-8942.

**Section One: Background Information**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reason for appointment: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care Provider: Name, Address, & Fax: \_\_\_\_\_

Specialty Care Providers: Names, Full Addresses, & Faxes (Please attach separate sheet if needed):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section Two: Cancer**

Please list all types/locations of cancer: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Cancer Treatment: Please describe your cancer treatment, list types of treatment (including surgery, chemotherapy, radiation therapy or other cancer treatments).**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you experience any major complications from your cancer treatment? Please describe:

\_\_\_\_\_  
\_\_\_\_\_

**Section Three: PsychoSocial History**

**Family History:** Please list all family members with a history of cancer and/or swelling, what problem they each had, along with their relationship to you:

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**Social History:**

**Marital Status:**    **Married**       **Single**       **Widowed**       **Life Partner**

**Employment Status:**     **Employed**       **Unemployed**       **Retired**

What is/was your occupation? \_\_\_\_\_

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**Daily Activities:** Please list any activities that are performed on a daily basis (i.e. type of work, hobby, home chores, home making, etc.):

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**Physical Activity History:** Do you or have you ever exercised regularly? Describe.

What would you like to be able to do for exercise? \_\_\_\_\_

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What is the one activity you cannot do now that you most wish you could do?

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**Section Four: Medical History** Have you ever had any of the following? If yes, please describe.

Use additional sheet or add an attachment if necessary:

I. Fevers, Fatigue, Weakness: \_\_\_\_\_

II. Infections or immune system problems: \_\_\_\_\_

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III. Ear, Eyes, nose, throat, sinus problems: \_\_\_\_\_

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IV. Cardiovascular (heart disease, hypertension, heart surgery, vein or artery disorder or surgery, coagulation disorder or therapy):

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V. Lung (asthma, emphysema, cancer, lung surgery, etc.):

\_\_\_\_\_

VI. Gastrointestinal including stomach, intestinal, bowel: \_\_\_\_\_

VII. Kidney, Bladder, Urinary: \_\_\_\_\_

VIII. Endocrine including diabetes, thyroid: \_\_\_\_\_

IX. Skin diseases or skin conditions of any type, history of poisonous bite, rash:

\_\_\_\_\_

X. Muscular or joint problem, trauma, injury or surgery: \_\_\_\_\_

XI. Pain or limited range of motion: \_\_\_\_\_

XII. Neurologic problem: neuropathy, stroke, migraines, brain tumor:

\_\_\_\_\_

XIII. Difficulty walking or balancing: \_\_\_\_\_

XIV. Difficulty with hands or dexterity: \_\_\_\_\_

XV. Difficulty with speech or swallowing: \_\_\_\_\_

XVI. Mental Health (depression, anxiety, chemical abuse, memory problems, hospitalizations for mental health-please include all dates): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Section Five: Swelling & Edema**

(Fill out if you have **Swelling** or **Edema**. If no swelling, skip to **Section Six**)

**Swelling history:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list locations of swelling: \_\_\_\_\_

Please list approximate date of onset: \_\_\_\_\_

Has the swelling gotten better, worse, or stayed the same? What makes it get better or worse?

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Please list all treatments that have been tried including medications, bandages, garments, lymphedema therapy by a PT or OT lymphedema therapist.

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Have you ever had wounds? Please provide dates. Please provide treatment that was administered:

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Have you ever had cellulitis or infection related to edema? Please list approximate dates. Please include treatment including hospitalizations, antibiotics, topical preparations, creams and lotions.

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Have you ever had surgery or procedures performed for edema, veins, weight loss, or plastic surgical procedures? Please provide the date and result of each procedure.

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Have you ever had a blood clot in your arm or leg? Please list all occurrences and treatments.

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**Section Six: Meds/Allergies**

Medications: List all medications you take regularly or irregularly. Include over the counter medications, vitamins, supplements. Please include generic name and dosages. Attach a separate sheet if necessary. \_\_\_\_\_

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Allergies: Please list all allergies to medications and your reactions to them.

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How do you learn best?

- Discussion       Reading       Demonstration       Visual       Classroom
- Individual Instruction       Other \_\_\_\_\_

**Signature (of Patient or person filling out the form)**

\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

*Name of person filling out this form if not the patient* \_\_\_\_\_

*Relationship to patient* \_\_\_\_\_

