A WellSpring of Natural Health, PC

Person-Centered Health Care ◦ Natural Medicine for the Whole Family

Cancer Diagnosis and Treatment Form

Patient Name _____ Age _____

Cancer Diagnosis _____ Date of first diagnosis _____

Diagnosis made by _____ Second opinion(s) _____

Current Oncologist _____ Other Physicians _____

_____

Do you keep your oncologist informed of your nutrients, herbs, and other natural therapies? Y ____ N ____

If yes, please provide your oncologist's office location and phone number if possible.

_____

Have you undergone surgery for your condition? Y ____ N ____ If yes, when?_____

Please fill in the information about your cancer treatments. Use the lines below to add additional detail if necessary.

Chemotherapy: _____ past _____ currently

began on _____ (month/year)

treatment: _____ (# days) every _____ (# weeks) for _____ (# months)

Radiation: _____ past _____ currently

began on _____ (month/year)

treatment: _____ (# days) every _____ (# weeks) for _____ (# months)

Other (please describe): _____

_____

_____

_____

Please list all symptoms you are currently experiencing that may be related to your conventional medical treatment: _____

_____

_____

_____

A WellSpring of Natural Health, P.C.
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P: 503.526.0397 F: 503.643.4633 wellspringofhealth.com

Are you currently seeing any natural medicine practitioners regarding your cancer? (i.e., acupuncturist, homeopath, naturopathic physician, etc.) Yes ____ No ____ If yes, whom? _____

_____

Have you seen any natural medicine practitioners in the past? Yes ____ No ____

If yes, please list practitioners, condition, and brief summary of treatment?_____

_____

_____

What, if anything, do you feel has contributed to the onset of your cancer?_____

_____

_____

Are there any specific questions you would like answered today?_____

_____

_____

I understand and acknowledge that I am knowingly choosing the medical services provided at A WellSpring of Natural Health, P.C. ("WellSpring") as complementary to or instead of conventional medical and that I will inform the healthcare provider(s) at WellSpring of any and all conventional medical care that I am receiving or that I choose to discontinue. I further understand and acknowledge that I am solely responsible for the healthcare choices I make, including but not limited to my refusal to use or receive conventional medical diagnostic or treatment options or my discontinuation of treatments recommended or prescribed by previous or concurrent healthcare providers.

☑ _____

READ, UNDERSTOOD AND AGREED

PATIENT

_____ _____

Printed Name Date

_____

Signature (or Signature of Legal Guardian)