Oncology Spa Solutions®

CAT Form

Name: _____ **Date:**_____

Address: _____ **City**_____ **Zip:**_____

Email address: _____ **Date of Birth**_____/_____/_____

Phone: (_____) _____-_____ Referred by: _____

Emergency Contact name _____ **Phone: (_____) _____ - _____**

Doctor's Name _____ **Phone: (_____) _____ - _____**

SKIN:
Are you experiencing any skin issues/changes? YES _____ NO _____ If yes, explain_____

_____

SCALP:
Are you experiencing any scalp issues? YES _____ NO_____ If yes, explain_____

_____

Are you experiencing any hair loss? YES _____ NO _____ Do you wear a wig? YES _____ NO _____

NAILS:
Are you experiencing any finger/toenail issues? YES _____ NO _____ If yes, explain _____

_____

MEDICATIONS:

*Chemotherapy? YES _____ NO _____ Date started/ended Chemo _____ Last Infusion _____

Name of Chemo drug/s and all other medications_____

_____

LIST CURRENT SKIN CARE PRODUCTS THAT YOU ARE USING: (cleansers, moisturizers, etc…)_____

_____

_____

ALLERGIES:

Please list all known allergies (food, drugs, etc). _____

_____

PLEASE ANSWER THE FOLLOWING:

*** Type of Cancer** _____ **Date Dx**_____ **Modifications/TX Plan**

Circle YES or NO

*YES / NO **Surgery** / Date/s _____ _____

*YES / NO **Incision Site** / Location _____ _____

*YES / NO **Port, PICC, Omaya** / Location_____ _____

*YES / NO **RT** / Dates of last treatment _____ _____

*YES / NO **Radiation Dermatitis** / Location: _____ _____

*YES / NO **LNodes removed/radiated** / # and location: _____ _____

*YES / NO **Lymphedema** / Location/side: _____ _____

*YES / NO **Swelling, Inflammation** / Location: _____ _____

*YES / NO **Pain, Burning** / Location:_____ _____

*YES / NO **Poor wound healing** / Explain: _____ _____

*YES / NO **Hypersensitivity or Irritation** / Explain: _____ _____

*YES / NO **Dryness** / Explain: _____ _____

*YES / NO **Rashes** / Explain: _____ _____

*YES / NO **Peripheral Neuropathy** / Explain: _____ _____

*YES / NO **Hand/Foot Syndrome (PPE)** / Explain: _____ _____

*YES / NO **Fatigue** / Explain: _____ _____

*YES / NO **Shortness of breath** / Explain: _____ _____

*YES / NO **Chills or Loss of balance** / Explain: _____ _____

*YES / NO **Claustrophobic** / Explain: _____ _____

*YES / NO **Anything your Dr. asked you to avoid?** _____ _____

_____ _____

* **TOP 3 concerns/needs for today**: 1) _____

2) _____

3) _____

I acknowledge that all the information provided by me is true and correct to the best of my knowledge. And it has been 48 hours since my last Chemotherapy infusion . I also understand that due to my medical history, cancer therapy and medications that some conditions may require more than one treatment to achieve the desired results.

Signature _____ Date: _____/_____/_____

Staff Signature _____ Date: _____/_____/_____