



CANCER-CERVICAL

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. List date of diagnosis: _____

2. What stage was the cancer?

<input type="checkbox"/> Stage 0 (in-situ)	<input type="checkbox"/> Stage II
<input type="checkbox"/> Stage Ia	<input type="checkbox"/> Stage III
<input type="checkbox"/> Stage Ib	<input type="checkbox"/> Stage IV

3. How was the cancer treated? (check all that apply)

<input type="checkbox"/> Cone surgery
<input type="checkbox"/> Total hysterectomy
<input type="checkbox"/> Radiation therapy
<input type="checkbox"/> Chemotherapy

4. Indicate date treatment was completed: _____

5. Has there been any evidence of recurrence?

<input type="checkbox"/> no
<input type="checkbox"/> yes; give details: _____

6. List all medications client is taking. (accurate name, dosage, and reason)

7. Are there any other health issues? (additional questionnaires may be required)