



**PATIENT DATA SHEET**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
Last First

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ Gender: Male  Female

**EMAIL:** \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street/Apt # City State Zip

PHONE #: \_\_\_\_\_  
Home Cell

OCCUPATION: \_\_\_\_\_ WORK#: \_\_\_\_\_

**PHYSICIAN INFORMATION:**

\_\_\_\_\_  
Medical Oncologist Phone

\_\_\_\_\_  
Primary Care Phone

SIGNIFICANT OTHER/CAREGIVER NAME: \_\_\_\_\_

RELATIONSHIP to you: \_\_\_\_\_ PHONE #: \_\_\_\_\_

**EMERGENCY CONTACT (other than caregiver):**

\_\_\_\_\_  
Name/Relationship to you Phone

IS FLORIDA YOUR PRIMARY RESIDENCE?  
Circle YES or NO (If no, please provide primary residence information):

\_\_\_\_\_  
Street/Apt # City State Zip Phone



### Consent Form

I [redacted] hereby give informed consent for myself to participate in the integrative cancer care program offered by the Sari Asher Center for Integrative Cancer Care ("Sari Center"), an initiative of the Palm Beach Cancer Institute Foundation, Inc. ("PBCIF"). I understand that the services rendered may include: massage therapy, reflexology, acupuncture, counseling, education, yoga/guided meditation, Qi Gong, stretching & flexibility classes, support groups, nutrition consultation, Healing Touch, lymphedema treatment, hypnotherapy, and any other complementary cancer therapy treatments as coordinated by the Sari Center interdisciplinary team in collaboration with my physician. I acknowledge that the Sari Center is an integrative center and does not offer "alternative" therapies in lieu of traditional medical treatment.

I recognize that services are rendered without distinction due to race, color, nationality, handicap, age, gender, sexual orientation, or socioeconomic status. I understand that these services are provided in person at the Sari Center or in some cases, specifically designated PBCIF satellite locations. I acknowledge that fees for service are designated at the time of my initial assessment, and payment is due at the time of treatment or in the event of a cancellation.

I am aware that the Sari Center therapists are licensed and trained professionals qualified to provide the services advertised, however I recognize that some of my needs may not be met via the integrative therapies offered. I understand that if necessary, and at the discretion of the professionals, I will be referred to my physician and/or other organization for services not provided by Sari Center treatment providers.

In addition, I understand that a parent/guardian's consent for participation is required if minors under the age of eighteen (18) are included in Sari Center programs.

The Sari Center adheres to all HIPAA laws of privacy. By providing my signature below, I acknowledge receipt of the **Notice of Privacy Practices** for Personal Health Information (PHI), and that I understand PHI uses and reasons for disclosure. While I understand that the Sari Center interdisciplinary team respects confidentiality of the patient as pursuant to Florida law and federal HIPAA regulations, I also understand that the Florida State law requires the reporting of any suspected abuse, neglect, or exploitation of a child or elderly person.

I understand that I am fully responsible for all of my personal articles (money, jewelry, clothing, etc.) while I am receiving Sari Center services. I hereby fully release the Center and PBCIF from any and all liability resulting from a loss by whatever means.

Finally, I acknowledge that I have access to copies of the Center's **Cancellation Policy**, the **Patient Bill of Rights & Responsibilities**, the **Patient Code of Conduct**, and the **PET/CT Scan Policy**. I understand that my eligibility for continued receipt of services at the Sari Center is contingent on my compliance as designated on the above mentioned policies, and that termination of services may result in cases of violation.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

Sari Asher Center for Integrative Cancer Care  
3401 PGABld. #200  
Palm Beach Gardens, FL 33410

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

## PATIENT ASSESSMENT FORM

### I. MEDICAL STATUS

1. What kind of cancer do you have/stage? \_\_\_\_\_
2. When were you diagnosed? (Include all cancers, and recurrence dates, if any)  
\_\_\_\_\_  
\_\_\_\_\_
3. Are you currently in treatment? Please explain:  
\_\_\_\_\_  
\_\_\_\_\_
4. What other illnesses or chronic conditions do you have besides cancer?  
\_\_\_\_\_  
\_\_\_\_\_
5. List your current routine or as-needed prescriptions, including vitamins, supplements, and over the counter medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### II. PRESENTING INFORMATION

1. What is your primary reason for coming to the Sari Center?  
\_\_\_\_\_  
\_\_\_\_\_
2. Please check off your symptoms/areas of concern:

<input type="checkbox"/> pain
<input type="checkbox"/> fatigue/weakness
<input type="checkbox"/> neuropathy
<input type="checkbox"/> lymphedema
<input type="checkbox"/> balance/mobility issues
<input type="checkbox"/> smoking
<input type="checkbox"/> recent recurrence

<input type="checkbox"/> loss of appetite
<input type="checkbox"/> weight loss/gain
<input type="checkbox"/> nausea/vomiting
<input type="checkbox"/> diarrhea/constipation
<input type="checkbox"/> swallowing issues
<input type="checkbox"/> nutrition questions
<input type="checkbox"/> special diet

<input type="checkbox"/> anxiety
<input type="checkbox"/> depression
<input type="checkbox"/> grief & loss
<input type="checkbox"/> sleep disturbance
<input type="checkbox"/> marital/relationship issues
<input type="checkbox"/> family/caregiver issues
<input type="checkbox"/> employment/financial issues

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

3. Of the problems identified above, please prioritize the areas of concern you wish to address at the Sari Center:

\_\_\_\_\_

4. Please circle the number from 0-10, (0 being “the worst it has been lately,” compared to 10 being “the best it has been lately”) that best describes your present status:

**My Physical Status**

(how my body feels overall – considering my energy, pain, sleep, nausea, appetite, etc.)

0    1    2    3    4    5    6    7    8    9    10

**My Emotional Status**

(my mood in general- considering my anxiety, depression, fearfulness, etc)

0    1    2    3    4    5    6    7    8    9    10

**My Personal Relationships/Support System**

(how I rate the support of my relationships with my partner/spouse, family, friends, etc.)

0    1    2    3    4    5    6    7    8    9    10

**My Overall Quality of Life**

(how I rate my **actual** quality of life in general, *at this time*)

0    1    2    3    4    5    6    7    8    9    10

**III. NOTES**

**Please let us know if you have any additional concerns or issues you would like us to be aware of right now.**

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