CANCER SUPPORT SANCTUARY
LARCC

Office Use Only	
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P	☐

CLINICAL INFORMATION RECORD

NAME:……...

ADDRESS:……

……..

TELEPHONE:…… MOBILE……

E-MAIL:……

OCCUPATION/PROFESSION:……

DATE OF BIRTH:……

MARITAL STATUS: M ☐ S ☐ W ☐ Other ☐

CHILDREN

	Boys	Girls
0 - 7 years	☐ 0 - 7 years	☐
7 - 14	☐	☐ 7 - 14
14 - 21	☐	☐ 14 - 21
21+	☐ 21+	☐

NEXT OF KIN

NAME:……...

ADDRESS:……

……..

TELEPHONE:……

GENERAL PRACTITIONER

NAME & ADDRESS:……..….

……

TELEPHONE NO:…….

CONSULTANT:……HOSPITAL……

CANCER DIAGNOSIS:…….

TREATMENTS: Surgery ☐ Chemotherapy ☐ ☐ Radiotherapy

Hormonal Therapy ☐ Immunotherapy ☐

Please indicate that you have spoken to your Consultant or G.P and he/she feels that complimentary therapies are appropriate for you:

Spoken to G.P/Consultant and date: _____.

If your Doctor requires any further information, please ask them to call us on 044 9371971.

MEDICAL HISTORY

INCLUDING ALL SURGERIES AND TREATMENTS…..…….

…….

…….

MEDICATION:…….

…….

SYMPTOMS & PROBLEMS:……

…….

…….

HERBAL TREATMENTS
& COMPLEMENTARY THERAPIES:…….

…….

……

SLEEP PATTERNS:…….

……
ANY HISTORY OF
PSYCHOLOGICAL/PSYCHIATRIC ILLNESS:…….

……

……

ANXIETIES OR FEARS,
RELATIONSHIPS/FAMILY
OR ANY SEXUAL ISSUES:…….

…….

…….

PREVIOUS EXPERIENCE OF
COUNSELLING OR OTHER …….

……...

ANYTHING ELSE YOU
WOULD LIKE US TO KNOW:……..

……..

……..

HOW DID YOU HEAR ABOUT LARCC?……

……..

IF YOU HAVE ANY SPECIFIC DIETARY REQUIREMENTS PLEASE INDICATE BELOW:

……..

……

CONSENT FOR TREATMENT:

SIGNED_____ **DATE**_____