SPABLUE ONCOLOGY WELLNESS CLIENT STORY

Date _____/___/_____

First Name: _____ Middle Initial: _____ Last Name: _____

Are you currently taking medication? □ Yes □ No
If yes, please list.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please provide a brief explanation why you are taking them.

_____
_____
_____
_____

HISTORY OF CANCER

What type of cancer(s) have you been diagnosed with?

_____

How long ago?

_____

Have you had any bone involvement? □ Yes □ No
If yes, where?

_____
_____
_____

Do you use any medical devices? □ Yes □ No
If yes, where?

_____
_____
_____
_____

_____
Signature: