Special Guest Questionnaire

(Please fill out and return or bring to first appointment)

1. Name:_____Birthdate_____
2. Address:_____
3. Home Phone:_____ Cell Phone:_____
4. Email:_____
5. Emergency Contact Name and Number:_____
6. Type of Cancer:_____
7. Type of Treatment:_____
8. Place of Treatment:_____
9. Physicians Name:_____
10. Contact Number of Physician:_____
11. Type of Services Interested in:
    a. Skin care ___
    b. Massage ___
    c. Pedicure ___
    d. Manicure ___
    e. Reiki ___
    f. Facial ___
    g. Hair or wigs ___
    h. Relaxation techniques ___
    i. Reflexology of feet ___
12. Will you need help with any of the following:
    a. Transportation: yes or no
    b. Child Care: yes or no
    c. _____
13. Are any of these a concern to you at present:
    a. Financial concerns: yes or no
    b. Insurance problems: yes or no
    c. Copays or obtaining your medication: yes or no
    d. Spiritual Concerns: yes or no
    e. Domestic abuse: yes or no
    f. Any other problems we have not identified but you would like help with:

All patients must be undergoing active treatment for Cancer with a written consent from their physician. Physician Consent Forms are available at www.thehealingnest.org or by emailing: thehealingnest@comcast.net. A consent form must be on file in order to participate.

All information will be kept confidential.

Signed: _____Date:_____