PHOENIX CANCER SUPPORT NETWORK NEW CLIENT QUESTIONNAIRE

To be completed by the patient or caregiver

1. General Info

   Last Name: First Name:

   Date of Birth: Sex: Male or female

2. Contact info

   Address: City/State/Zip:

   Home phone number:

   Mobile phone number:

   Email:

   Emergency Contact Name and Phone:

3. Physician Name, Address and Phone number:

4. Are you in active treatment? ☐yes ☐no

5. Cancer Type: Age(s) at Diagnosis: Hospitals where treated:

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6. PCSN requested services: please check all that may apply.

Service	Yes	No
☐ Transportation to and from Medical Appointments	☐yes	☐no
If yes, do you require medical equipment?	☐yes	☐no
☐ Patient advocate	☐yes	☐no
☐Estate Planning	☐yes	☐no
☐ Meal Delivery	☐yes	☐no
If yes, do you have any dietary restrictions?	☐yes	☐no
☐Assistance with Errands/Grocery Shopping	☐yes	☐no
If yes, do you require a wheelchair?	☐yes	☐no
☐ House Cleaning	☐yes	☐no
☐ Collection and Collation of Medical Records	☐yes	☐no
☐ Child Care	☐yes	☐no

☐ Other: Please Describe: