Name: _____ Date: _____

# Oncology Rehabilitation Screening

You can bring this form to your next appointment with your oncologist or infusion center and ask to meet with an oncology physical therapist. Contact Lisa at 719-530-2392 for more information

CHECK ALL THAT APPLY:

- ☐ Difficulty moving your head for talking to others, or looking side-to-side for driving
- ☐ Feel limited in your ability to walk in the community for prolonged distances, such as shopping or doctors' appointments
- ☐ Difficulty reaching overhead, into cabinets, reaching behind your back or carrying heavy items
- ☐ Difficulty completing moderate activity around your house, such as: carrying groceries, lifting a gallon of milk, doing laundry, preparing meals
- ☐ Changes to voice
- ☐ Increased effort required with getting up and down from chairs, sofas, toilets
- ☐ Difficulty getting dressed, bathing, or taking care of yourself
- ☐ Pain that is limiting your function
- ☐ Difficulty with urination and/or defecation
- ☐ Difficulty enjoying or returning to normal recreational activities
- ☐ Difficulty swallowing or unintentional weight loss
- ☐ Fatigue or weakness interferes with your ability to complete your daily activities or do the things you would like
- ☐ Had a fall or near fall in the past 3 months, or feel the need to reach for furniture or walls for stability
- ☐ Noticed a decline in your balance. Feel unsteady on your feet. Have trouble walking on grass, down the driveway, or negotiating a curb safely
- ☐ New onset of dizziness or vertigo
- ☐ Numbness/tingling in the extremities that affects your daily function or fine motor skills
- ☐ Noticed heaviness or increase in swelling in your arms or legs
- ☐ Experience tightness or decreased motion around an area of surgical or radiation treatment
- ☐ Pain with intimacy. Pain or numbness in your genitals with intimacy and/or intercourse.
- ☐ Difficulty exercising on your own or unsure how to exercise safely during cancer treatments

Continued...

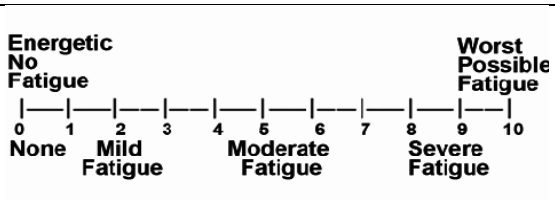
FATIGUE

Consider the past several weeks.

Using this scale, please rate your:

Current Fatigue Level: _____

Worst Fatigue Level: _____




Any other concerns that you'd like to speak to an oncology physical therapist about:

For therapist use only