For staff use
Received by______________________ Date______________
PEP/Staff____________________

☐ Educational Program
☐ Look Good Feel Better
☐ Nutrition Consult
☐ Support Group
☐ Walk-in
☐ Other_____________________
☐ Exercise Consult
☐ Networking Group
☐ Social Event
☐ Support/Information Consult
☐ Wig Consult
☐ Welcome to Wellness

☐ Main Location, Hinsdale ☐ Other Location (location name)______________________

Program Referral:
☐ Family Matters ☐ Healthy Living ☐ Information/Education ☐ Nutrition ☐ Stress Management ☐ Support/Network

Welcome to Wellness House. Please take a few minutes to complete this *confidential* information form as completely as possible. Your personal information will *only* be used for registration and record keeping and is never shared with outside sources. The information provided here is used to help develop and recommend programs and to generate the funding that allows Wellness House to continue to serve those affected by cancer in the most effective ways possible.

PLEASE PRINT

Today's Date___/___/___

☐ Name____

Date of Birth______/______/_______________

Address____

Preferred phone_________________________

City____________ State__________ Zip code______________

How should we contact you? ☐ email ☐ phone
May we leave a message? ☐ yes ☐ no

Email address____

Emergency Contact Name_________________
Emergency preferred phone #______________

Gender ☐ Male ☐ Female ☐ Transgender ☐ Gender non-binary ☐ Other

Cancer Situation

☐ **I am the person with cancer**

Date of original cancer diagnosis____

Primary cancer type____

Cancer stage (please circle) 0 I II III IV

Has cancer recurred? ☐ yes ☐ no Date________________
Has cancer spread? ☐ yes ☐ no Date________________
Location ☐ Lymph Nodes ☐ Liver ☐ Lung ☐ Brain ☐ Bone/Spine ☐ Other______________

Medical Oncologist__________________________ Hospital ________________________

Radiation Oncologist________________________ Hospital ________________________

Surgical Oncologist__________________________ Hospital ________________________

☐ **A friend/family member has cancer His/her name is_____________________________**
Your relationship to the person diagnosed______________________________________

Date of original cancer diagnosis____

Primary cancer type____

Cancer stage (please circle) 0 I II III IV

Has cancer recurred? ☐ yes ☐ no Date________________
Has cancer spread? ☐ yes ☐ no Date________________
Location ☐ Lymph Nodes ☐ Liver ☐ Lung ☐ Brain ☐ Bone/Spine ☐ Other_____________

Medical oncologist__________________________ Hospital _________________________

Radiation oncologist_________________________ Hospital_________________________

Surgical oncologist__________________________ Hospital_________________________

Treatment Status
☐ Active treatment
☐ Completed treatment during past 18 months
☐ Pre-treatment
☐ Recently completed treatment/taking oral hormones
☐ Supportive care only
☐ Treatment completed more than 18 months ago
☐ Other_________________________________

Treatment Types
☐ Bone marrow/stem cell transplant
☐ Chemotherapy
☐ Hormonal therapy
☐ Radiation
☐ Surgery
☐ Targeted therapy
☐ Treatment decisions being made
☐ Watch and wait
☐ Other______________________

Primary language spoken in your home? ____

Have you served in the military? ☐ yes ☐ no

Marital Status
☐ Single ☐ Widowed
☐ Married ☐ Committed Relationship
☐ Divorced/Separated
Spouse/Significant other's name___________________

Race/Ethnicity
☐ White, Non-Hispanic/Latino ☐ Asian
☐ Hispanic/Latino ☐ Native Hawaiian
☐ African-American/Black ☐ Pacific Islander
☐ Other ☐ Multi-racial
☐ Native American/Alaskan

Highest Level of Education
☐ Elementary ☐ Masters
☐ High School ☐ Doctorate
☐ College

Employer____
Occupation_______________________________________
☐ Full-time ☐ Part-time ☐ Medical leave ☐ Retired ☐ Student ☐ Not employed

Medical Insurance Status
☐ Insured
☐ Underinsured
☐ Uninsured

Household Income
☐ less than $20,000
☐ $20,000 to $34,000
☐ $35,000 to $49,000
☐ $50,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 +

Family member(s) *currently* living with you
Adult(s):

Name (first and last)	Birthdate	Gender	Race	Marital Status	Employment Status
☐ (1)________________________	__/____/____	________	_______	__________	________________

Cell phone:________________ Email:_____________________

☐ (2)________________________	__/__/____	________	_______	___________	_________________

Cell phone:________________ Email:_____________________

Children *currently* living with you:

Name (first and last)	Birthdate	Gender	Race
☐ (1)________________________	__/____/____	________	_______

Cell phone:________________ Email:_____________________

☐ (2)________________________	__/__/____	________	_______

Cell phone:________________ Email:_____________________

What do you hope to gain from participating in a Wellness House program?

☐ Join an exercise program
☐ Connect with others experiencing cancer
☐ Find ways for managing stress
☐ Find support for family:___children___teen___spouse___other
☐ Learn new information about cancer and its treatment
☐ Learn about nutrition and cancer
☐ Join a support group
☐ Find ways to manage the side effects of treatment
☐ Learn about other community resources
☐ Other__________________________________

How did you find out about Wellness House?

☐ Doctor/Doctors office (name of Doctor)_________________________
☐ Employer
☐ Family/Friend/Co-worker

- ☐ Flyer
- ☐ Hospital
- ☐ Internet search
- ☐ Newspaper
- ☐ Nurse/Social Worker/Healthcare professional (name)________________
- ☐ Online media (Metromix, online newspaper/magazine)
- ☐ Other____
- ☐ Religious organization
- ☐ School
- ☐ Social media (Facebook, Twitter)
- ☐ Wellness House flyer
- ☐ Wellness House website
- ☐ Wellness House program calendar