Stewart's CARING PLACE
CANCER WELLNESS CENTER

Registration Form

Please complete all fields on both sides to help us better serve you

Date _____

Name _____ **DOB** _____

Address _____**City** _____ **State** _____ **Zip** _____

County _____ **Primary Phone** _____ **Secondary Phone** _____

Email _____ **Gender** M F Other _____

Occupation _____ **Employer** _____

Emergency Contact

Name _____ Phone _____ Relationship _____

Check which best describes you (select all that apply)

___Diagnosed with Cancer Type of Diagnosis _____

___ Caregiver

___Seeking Grief Support

Other _____

My (circle below) has been diagnosed with cancer

Spouse/Partner Parent Child Sibling Friend

Name _____ Type of Diagnosis _____

I am interested in programs and services related to the following (check all that apply)

- ○ Support Groups
- ○ Individual Counseling
- ○ Wigs & Beauty
- ○ Nutrition & Meal Preparation
- ○ Food Pantry
- ○ Caregiver Support & Strategies
- ○ Financial or Legal Counseling
- ○ Physical Activity and Exercise
- ○ Massage & Reiki
- ○ Family & Youth Programs
- ○ Communicating with my Loved Ones
- ○ Long-Term Survivorship
- ○ Other: _____

If you are or have been treated for cancer, which type of treatment are/were you receiving? (Circle all which apply)

Surgery Chemotherapy Radiation Hormone Therapy Reconstructive Surgery

Name of Oncologist or Physician: _____

Which medical facility/provider are you or your loved one receiving care? _____

How did you hear about Stewart's Caring Place?_____

All programs and services at Stewart's Caring Place are provided at no-cost, regardless of income.
Some organizations who provide funding to our agency require us to collect statistical information in order to receive funding. Thank you for completing the below. Your individual information will never be released.

Please indicate which best describes your current health care coverage (circle all that apply)

Private Insurance	Medicare	Medicaid	No health care coverage	Applying for coverage

Ethnicity (circle one)

African American	Asian	Middle Eastern
African Born	Caucasian	Native American
Arab American	Hispanic	Other_____

Annual Household Income (circle one)

Less than $5,000	$15,000-$19,999	$50,000-$59,000	$80,000-$99,999
$5,000-$9,999	$20,000-$39,000	$60,000-$69,999	$100,000+
$10,000-$14,999	$40,000-$49,000	$70,000-$79,000	Unknown

Source(s) of income _____

Total number of individuals living in the household_____

Number of minors living in the household_____

I understand and agree that my consent to these services is given in consideration of my being permitted to participate in the complementary or alternative health care services provided by Stewart's Caring Place. I acknowledge that I am a voluntary participant in these activities and assume full and complete responsibility for any injury, loss, or damage which may occur during my participation in these events or while on the premises of Stewart's Caring Place. I hereby release and hold harmless Stewart's Caring Place, the complementary or alternative health care provider, and all employees, agents, and directors of Stewart's Caring Place for any and all claims, causes of action, suits or other proceedings which in any way relate to my participation in the complementary or alternative health care services upon the premises of Stewart's Caring Place for personal injuries or any other damages sustained. I have received a copy of the policies of Stewart's Caring Place and acknowledge my understanding of them.

Signature: _____ Date: _____

Staff Notes

Database Entry Date: _____