Participant and Caregiver Registration Form

Welcome to Stewart's Caring Place: Cancer Wellness Center.
Please complete the following information to help us better serve you.

Date: _____ Tour Given: No or Yes Date of Tour: _____ Int: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Secondary Phone: _____

Email Address: _____ Gender: M F Marital Status: _____

Participant: **Emergency Contact: _____**

Check which best describes you:

____ Recently diagnosed with cancer
____ Currently in treatment for cancer
____ Finished treatment less than six months ago
____ Finished treatment between six months and One year ago
____ Long-term cancer survivor

If you have been diagnosed with cancer, please list your diagnosis. _____

If you are being treated for cancer or have been treated for cancer, please check any pertinent therapies:

□ Surgery □ Chemotherapy □Radiation □ Hormone Therapy □ Reconstructive Surgery

At which hospital are you or your loved one receiving care? Check all that apply.

Summit County
____ Akron Children's Hospital
____ Cleveland Clinic Akron General
____ Summa Akron City Hospital (includes Cooper Cancer Center)
____ Summa Western Reserve Hospital

Cuyahoga County
____ Cleveland Clinic
____ MetroHealth System
____ University Hospitals (includes Seidman Cancer Center)
____ VA Hospital

Stark County
____ Alliance Community Hospital
____ Aultman Hospital
____ Mercy Medical Center

Portage County
____ Robinson Memorial Hospital

Medina County
____ Medina Hospital
____ Summa Lake Medina
____ Summa Wadsworth-Rittman Hospital
____ University Hospitals Sharon Center

Other
_____
_____

Caregiver:

Check which best describes you:

____ Spouse/Partner of someone in treatment
____ Parent of someone in treatment
____ Sibling of someone in treatment
____ My loved one is in hospice care
____ Bereaved
____ Other: _____
____ My loved one is a participant at Stewart's Caring Place (Name) _____

(over, please)

I would like help with the following:

□ Fatigue or loss of sleep
□ Caregiving strategies
□ Anxiety, depression or sadness
□ Communicating with my Children, family and friends
□ Long-term survivorship
□ Hair thinning or hair loss
□ Spiritual concerns
□ Financial concerns
□ Relationships and intimacy
□ Referral to the American Cancer Society
□ Loss of appetite and nutrition
□ Meal preparation for a loved one
□ Physical activity and exercise
□ Grieving
□ Other: _____

How can Stewart's Caring Place be helpful to you and your family?

_____

Do you have children or grandchildren under the age of 18 who either live in your home or spend time with you in your home?

□ Yes □ No Names and ages: _____

How did you hear about Stewart's Caring Place?

_____

Would you like information about volunteering? □ Yes □ No

****Thank you for providing this information as we provide services at no cost to you through grants and donations. ****
This information is used for statistical purposes only. Your individual information will never be released.

Please indicate which best describes your health care coverage. Check all that apply:

Private Insurance Medicare Medicaid No health care coverage Applying for coverage

Income Level

$0 - $14,999 $15,000 - $29,000 $30,000 - $44,999 $45,000 - $59,000 $60,000 +

How many people live in your home? _____ **Race:** _____

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 participant 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 Only

Notes:_____
_____
_____
_____
_____

Database Entry Date: _____