Participant Information Form

Welcome to Waterford Place. Please take a few minutes to complete this confidential information form. Your personal information will only be used for registration and record keeping and is never shared with outside sources. This information provided here is used to help develop and recommend programs and to generate the funds that allows Waterford Place to continue to serve those impacted by cancer in the most effective ways possible.

Today's Date: ______/_______/______

Personal Information *(Please Print)*

Name: ____

Address: ____

City: ______________________ State _______ Zip ________

Date of Birth: ___________________ Gender: ☐ M ☐ F

Veteran: ☐ Yes ☐ No

Preferred Phone: ______________________________

Alternative Phone: ______________________________

Can Waterford Place leave a message? Yes No

Email Address: ________________________________

Emergency Contact: ____________________________

Emergency Contact Phone: ______________________

Current Cancer Situation

☐ I am the person diagnosed with cancer

☐ Family member or friend has cancer

Family member/Friend's name: _________________________

Your relationship to Family/Friend: ______________________

Primary cancer type: ______________________ Stage ☐ 0 ☐ I ☐ II ☐ III ☐ IV

Date of original cancer diagnosis: ___________

Has cancer recurred? ☐ Yes ☐ No If yes, date of recurrence: ___________

Has cancer metastasized / spread from its original location? ☐ Yes ☐ No

Cancer Treatment Provider: ________________________

If yes, date you learned of mets / spread __________________

Treatment Status *(check the box that best describes your current state)*

☐ Pre-treatment

☐ In active treatment

☐ Completed treatment (date completed _________________)

☐ Supportive or Palliative care only

Treatment Received / Receiving

☐ Treatment decisions being made

☐ Watch and Wait

☐ Surgery

☐ Chemotherapy or targeted therapy

☐ Radiation

☐ Bone marrow / stem cell transplant

☐ Oral hormones / Hormone therapy

☐ Integrated/ complementary approaches

☐ Other: __________________________________

Your Health

Participant Name: ____________________________

Do you have any major medical issues? ☐ Yes ☐ No

If yes, briefly explain: ____

Have you ever engaged in counseling to help you feel better mentally / emotionally? ☐ Yes ☐ No

If yes, are you currently working with a counselor? ☐ Yes ☐ No

Have you ever been prescribed medication to help you feel better mentally / emotionally? ☐ Yes ☐ No

If yes, please list issue(s) addressed by medication:____

Your Relationship Status

☐ Single

☐ Married

(Spouse: ______________)

☐ Committed Relationship

(Partner: ______________)

☐ Separated / Divorced

☐ Widowed

Your Employment

Employer: ____________________________

Occupation: ____________________________

☐ Full Time ☐ Retired

☐ Part Time ☐ Student

☐ Medical Leave ☐ Not Employed

Your Race / Ethnicity

☐ White, Non-Hispanic/Latino ☐ Multi-Racial

☐ Hispanic / Latino ☐ Asian

☐ Black / African American ☐ Other

☐ American Indian / Alaskan Native

☐ Pacific Islander / Native Hawaiian

Your Medical Insurance Status

☐ Private Insurance

☐ Medicare

☐ Medicaid

☐ Uninsured

Your Primary Language

☐ English

☐ Spanish

☐ Other: ____________________

Your Highest Level of Education

☐ Grade School ☐ Graduate School

☐ High School ☐ Doctorate

☐ College

Family Member(s) Currently Living With You

ADULTS (Currently living with you)

Name *(include last name if different)*	Birth Date	Gender	Race	Marital Status	Empl. Status	Phone or Email
______________________	__________	☐ M ☐ F	_______	__________	__________	__________
______________________	__________	☐ M ☐ F	_______	__________	__________	__________

CHILDREN (Under 18 and that are living with you)

Name *(include last name if different)*	Birth Date	Gender	Race	Age	Grade in School
______________________	__________	☐ M ☐ F	_______	__________	__________
______________________	__________	☐ M ☐ F	_______	__________	__________
______________________	__________	☐ M ☐ F	_______	__________	__________
______________________	__________	☐ M ☐ F	_______	__________	__________

Participant Name: ___________________________________

What do you hope to gain as a result of coming to Waterford Place? *(please check all that apply)*

INFORMATION AND EDUCATION

- ☐ Learn new information about cancer and its treatment
- ☐ Learn about other community resources
- ☐ Find ways to manage the side effects of cancer

SUPPORT

- ☐ Connect with others who are experiencing cancer
- ☐ Get support for my family
- ☐ Learn how to manage my feelings about having cancer

WELLNESS

- ☐ Learn about nutrition and cancer
- ☐ Join a yoga or movement program

CHILDREN AND FAMILIES

- ☐ Find support for children
- ☐ Learn how to help support my children
- ☐ Have fun with my children

BEREAVEMENT

- ☐ Get support for my children
- ☐ Get support for myself

SALON AND SPA

- ☐ Wig Boutique
- ☐ Look Good, Feel Better
- ☐ Facial
- ☐ Massage

MIND ~ BODY ~ SPIRIT

- ☐ Take an expressive arts class
- ☐ Learn how to practice meditation or mindfulness
- ☐ Learn about Reiki and other energy therapies

How did you find out about Waterford Place?

- ☐ Waterford Place Program Guide or Flyer
- ☐ Waterford Place Brochure
- ☐ Waterford Place Website
- ☐ Rush-Copley Website
- ☐ Newspaper (*please specify*): _______________________________________
- ☐ Internet Search (*website name*):_____________________________________
- ☐ Healthcare Team
- ☐ Family / Friend / Co-Worker (*name*): __________________________________
- ☐ Other (*please specify*):____

Release and Waiver

I, the undersigned, acknowledge that I have voluntarily chosen to participate in the classes / programs / services offered by Waterford Place Cancer Resource Center. I am aware that participation in some of these classes / programs / services may require physical exertion and a minimum level of physical fitness. I am voluntarily participating in the classes / programs / services and I assume all responsibility and liability for any and all injuries I may sustain due to my participation in these activates. In consideration for participation in the classes/programs/services I waive any claims or liability against Waterford Place Cancer Resource Center and/or the Waterford Place Cancer Resource Center staff/ instructors/other participants for injury or damages that I may sustain as a result of my participation. I understand and agree that Waterford Place Cancer Resource Center, Rush-Copley Medical Center, Copley Memorial Hospital or any of their afflilates are not responsble for the loss or theft of any the Participant's personal items or valuables. Any items that remain in the Participant's possession will be their responsibility to secure. I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Participant Name (Please Print): ____

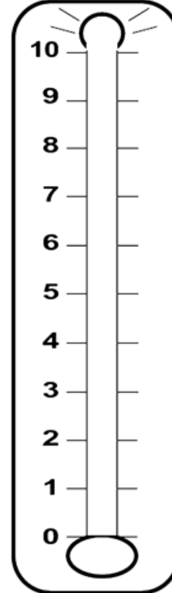
Participant Signature: ____ Date: ___________

If Participant is Under 18 years old:

Parent/Guardian Signature: ____ Date: ___________

Participant Name: ____ Today's Date: ______/_______/______

Please circle the number (0 – 10) that best describes how much distress you have been experiencing in the past week including today.



Please indicate if any of the following has been a difficulty for you in the past week including today.
(Be sure to check each area that is a concern.)

AREAS OF CONCERN	Check if Area is Concern
Child Care	☐
Housing	☐
Insurance	☐
Transportation	☐
Work / School	☐
Treatment Decisions	☐
Financial	☐
Appearance	☐
Bathing / Dressing	☐
Breathing	☐
Changes in Urination	☐
Constipation	☐
Diarrhea	☐
Eating	☐
Fatigue	☐
Feeling Swollen	☐
	☐

AREAS OF CONCERN	Check if Area is Concern
Fevers	☐
Getting Around	☐
Mouth Sores	☐
Nausea	☐
Nose Dry / Congested	☐
Pain	☐
Sexual	☐
Tingling in Hands and Feet	☐
Substance Abuse	☐
Dealing with Children	☐
Dealing with Partner	☐
Ability to Have Children	☐
Family Health Issues	☐
Depression	☐
Fears	☐
Nervousness	☐
Sadness	☐