



LivingWell Cancer Resource Center Participant Information Form

Date _____

Phone / Walk-In _____

Welcome to LivingWell Cancer Resource Center. Please take a moment to complete this confidential form to help us serve you better. Your personal information will not be shared with anyone outside of LivingWell. Thank you for your cooperation.

Your Information

Name: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** _____

Email Address: _____ **Gender:** ___ Male ___ Female **Date of Birth:** ___/___/___

Marital Status: ___ Single ___ Married ___ Divorced/Separated ___ Widowed ___ Committed Relationship

Race: ___ White, Non-Hispanic ___ Hispanic ___ African American ___ Asian ___ American Indian Other _____

Emergency Contact: _____ **Phone:** _____

You or your loved one's cancer experience

Name of Person with Cancer: ___ SELF or Name: _____ **Relationship to you:** _____

Primary Cancer Type: _____ **Cancer Stage:** _____ **Date of Diagnosis:** _____

Primary Oncologist/Cancer Specialist: _____ **Hospital:** _____

Treatment Status: ___ Pre-treatment ___ Active treatment ___ Completed treatment during past 18 months
 ___ Treatment completed more than 18 months ago ___ Completed treatment and still taking oral hormones
 ___ Supportive Care Only ___ Other _____

Who may we thank for referring you to LivingWell Cancer Resource Center (please check all that apply and fill in name if known)?

	Name
<input type="checkbox"/> Hospital	
<input type="checkbox"/> Doctor	
<input type="checkbox"/> Nurse	
<input type="checkbox"/> Family/Friend	
<input type="checkbox"/> Participant	
<input type="checkbox"/> Brochure	
<input type="checkbox"/> Newspaper	
<input type="checkbox"/> Religious Org.	
<input type="checkbox"/> LWCRC Website	
<input type="checkbox"/> Other Website	
<input type="checkbox"/> LWCRC Volunteer	
<input type="checkbox"/> LWCRC Board Member	
<input type="checkbox"/> Other	

Today I phoned ___ / visited ___ LivingWell Cancer Resource Center for:

- ___ General information about LWCRC
- ___ Resources (Library, referral to other resources, wigs, scarves)
- ___ To attend a Support Group
 Name of Group: _____
 Date Attended: _____
- ___ To attend a Mind Body Fitness Program
 Name of Program: _____
 Date Attended: _____
- ___ To attend a Special Presentation or other Educational program
 Name of Program or presentation: _____
- ___ Other _____

How would you prefer us to contact you?

___ Phone If you select "Phone", may we leave a message? Yes No

___ Email

___ No, I would not like to be contacted.

PLEASE READ AND SIGN THE WAIVER ON THE BACK OF THIS FORM