

**Wellness Program
Participant Registration Form**

DATE: _____

Please check the program(s) you will be attending:

<input type="checkbox"/> Healing Touch	<input type="checkbox"/> Painting	<input type="checkbox"/> Yoga for Strength & Empowerment
<input type="checkbox"/> Journaling/Poetry	<input type="checkbox"/> WellFit – Santa Barbara	<input type="checkbox"/> Tai Chi Yoga
<input type="checkbox"/> Restorative Yoga	<input type="checkbox"/> WellFit - Lompoc	<input type="checkbox"/> Other: _____
<input type="checkbox"/> QiGong	<input type="checkbox"/> WellFit – Santa Ynez	
<input type="checkbox"/> Nutrition _____	(title of class)	

NAME: _____ Male Female DATE OF BIRTH: _____

HOME ADDRESS: _____

City/State: _____ Zip Code: _____

Home phone: _____ MSG OK Cell phone: _____ MSG OK

Email: _____

Would you like to receive information about this or other Cancer Center programs electronically? Yes No

EMERGENCY CONTACT: Name: _____ Phone #: _____

PARTICIPANT SCREENING TOOL:

In the last **3 months**, have you experienced (*please check all that apply*)

- | | |
|---|--|
| <input type="checkbox"/> Unusual shortness of breath | <input type="checkbox"/> Advice from a physician not to exercise |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> History of fractures |
| <input type="checkbox"/> Light-headedness or fainting | <input type="checkbox"/> Difficulty with physical exercise |
| <input type="checkbox"/> Numbness or lack of feeling in hands or feet | <input type="checkbox"/> Other (<i>please explain</i>) _____ |

****Please note that all of our programs are designed for your comfort and enjoyment and that participation in them does not substitute for medical care or psychosocial counseling/support. Please go at your own pace and do only as you are able, particularly if you have checked off any of the above circumstances. If you feel uncomfortable at any time during any program, please be aware that you may leave at any time.**

PARTICIPANT SIGNATURE: X _____

MY RELATIONSHIP TO THE PATIENT: (*Check your primary role related to the current cancer experience*)

- I am the patient/survivor
- I am a spouse or significant other
- I am related to the patient as:
- | | | | |
|-----------------------------------|----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Granddaughter |
| <input type="checkbox"/> Daughter | <input type="checkbox"/> Son | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Aunt |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandson | <input type="checkbox"/> Uncle |
- I am a friend
- Other (*please define*) _____

PATIENT'S TYPE OF CANCER: _____ DATE OF DIAGNOSIS (*month/year*): _____

TREATMENT STATUS:

- Currently receiving cancer treatment
- Finished with cancer treatment. Date of **last** treatment (*month/year*) _____

TYPE OF TREATMENT (*check all that apply*):

- Surgery Radiation Chemotherapy Other (*please define*) _____

PROVIDER OF CANCER CARE/TREATMENT (*please check all that apply*)

- Cancer Center of Santa Barbara Santa Barbara Hematology/Oncology Medical Group
- Sansum Clinic (oncology) Solvang Clinic (Drs. Walker and Bryce)
- Other _____

ONCOLOGIST (*please check all that apply*)

- Dr. Abate Dr. Blount Dr. Bryce Dr. Cheng Dr. Greenwald
- Dr. Gupta Dr. Kass Dr. Newman Dr. Suh Dr. Taguchi
- Dr. Walker Dr. Weisenburger Dr. Woliver Other: _____

HAVE YOU PARTICIPATED IN OTHER WELLNESS PROGRAMS/SERVICES? (*please check all that apply*)

- Healing Touch Painting Yoga
- Journaling/Poetry WellFit – Santa Barbara Tai Chi Yoga
- QiGong WellFit - Lompoc WellFit – Santa Ynez
- Nutrition counseling Nutrition class _____ (title of class)
- Other (*please define*) _____

May we discuss your doctor(s) about your participation in these programs? Yes No

HOW DID YOU HEAR ABOUT WELLNESS PROGRAM CLASSES/ACTIVITIES? (*please check all that apply*)

- Program Calendar Flyers/posters/postcards Cancer Center website
- New patient folder/orientation Other patient/family member/friend Staff member
- Walked by Other _____

PARTICIPANT INFORMATION AND RELEASE

I have voluntarily chosen to take part in various activities offered by the Wellness Program at the Cancer Center of Santa Barbara. I understand that some activities may expose me to hazards or risks that could result in my injury and I understand and appreciate the nature of such risks and hazards. I wish to take part in these activities, and I accept the risk and hazards that may result from such participation.

I hereby release the Cancer Center of Santa Barbara, its directors and officers, employees, program facilitators/ instructors, and participating agencies from any and all claims for injuries or damages that may result from or occur during my participation in the Activity, including those arising from or contributing to any physical impairment or defect I may have, whether latent or patent. I agree that the Cancer Center of Santa Barbara and its employees, program facilitators/instructors, and participating agencies are under no obligation to provide physical examination or other evidence of my fitness or ability to participate in this Activity, this being my sole responsibility. Since participation is based on mutual consent, I understand that the right to terminate participation can be made by me, the Cancer Center, program facilitators/instructors, and/or participating agencies at will, with or without cause, at any time.

X _____
PARTICIPANT SIGNATURE

DATE