

Cancer Center of Santa Barbara Wellness Program

Registration and Informed Consent

Please check which Wellness class(es) 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"/> QiGong | <input type="checkbox"/> WellFit – Santa Ynez | |
| <input type="checkbox"/> Nutrition _____ | (title of class) | <input type="checkbox"/> Other: _____ |

Name: _____ Date of birth: _____

Phone: _____ MSG OK Address: _____

City: _____ Zip: _____ Email: _____

May we contact you about this or other Cancer Center programs? Yes No

How did you hear about this class?

- | | | |
|---|--|--|
| <input type="checkbox"/> Received information by mail | <input type="checkbox"/> Flyer/calendar at Cancer Center | <input type="checkbox"/> Cancer Center website |
| <input type="checkbox"/> Other patient/family member/friend | <input type="checkbox"/> Referred by staff | <input type="checkbox"/> Other: _____ |

Have you taken part in any other Cancer Center Wellness classes? If so, please list:

Which statement best describes you?

- Currently receiving cancer treatment
- Finished with cancer treatment. Please list **date of last treatment** (month, year): _____
- Spouse/family member of patient in treatment
- Other: _____

Cancer History *If you are a current or former patient, please answer the following cancer-related questions. If not, please skip to informed consent section.*

Type of Cancer _____ **Date of Diagnosis** _____ (month, year)

Type of Treatment (check all that apply):

- Surgery Radiation Chemotherapy
- Other (i.e. hormonal therapy): _____

Oncologist(s) (check all that apply):

- | | | | | |
|--------------------------------------|---------------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Dr. Woliver | <input type="checkbox"/> Dr. Kass | <input type="checkbox"/> Dr. Greenwald | <input type="checkbox"/> Dr. Weisenburger | <input type="checkbox"/> Dr. Cheng |
| <input type="checkbox"/> Dr. Blount | <input type="checkbox"/> Dr. Abate | <input type="checkbox"/> Dr. Newman | <input type="checkbox"/> Dr. Taguchi | <input type="checkbox"/> Dr. Gupta |
| <input type="checkbox"/> Dr. Walker | <input type="checkbox"/> Other: _____ | | | |

INFORMED CONSENT

Please note that all of our programs are designed for your comfort and enjoyment and that participation in them is voluntary and does not substitute for medical care or psychosocial counseling/support. Please go at your own pace and if you feel uncomfortable at any time, we encourage you to inform the instructor and, if necessary, you may leave at any time. Please sign and date that you have read and understand the above statements.

Signature _____

Date _____