

# ***Cancer Wellness Program Registration and Consent Form***

**Please check which class(es) you are registering for:**

- |  |   |
|--|---|
| <input type="checkbox"/> Healing Touch                     | <input type="checkbox"/> Poetry                       |
| <input type="checkbox"/> Laughter                          | <input type="checkbox"/> Qi Gong                      |
| <input type="checkbox"/> Gentle Yoga                       | <input type="checkbox"/> Wellfit Exercise Program     |
| <input type="checkbox"/> Yoga for Strength and Empowerment | <input type="checkbox"/> Other (please specify):_____ |
| <input type="checkbox"/> Painting                          |   |

**How did you hear about the Cancer Wellness Program and/or this class?**

- |  |  |
|--|--|
| <input type="checkbox"/> Received flyer/calendar in mail                 | <input type="checkbox"/> Flyer/calendar at the Cancer Center |
| <input type="checkbox"/> Flyer/calendar at Sansum/Cottage Hospital/Other | <input type="checkbox"/> Other patient/family member/friend  |
| <input type="checkbox"/> New patient teaching/new patient packet         | <input type="checkbox"/> Website                             |
| <input type="checkbox"/> Doctor, nurse, social worker, etc.: _____       | (name of staff person)                                       |
| <input type="checkbox"/> Other _____                                     |  |

**General Information (please print)**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone \_\_\_\_\_ (work) \_\_\_\_\_ (home)  
Email \_\_\_\_\_

**May we use the above information to contact you about your participation/interest in this or other Wellness Program activities?**    Yes   No

**Which statement best describes you:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Current patient                         | <input type="checkbox"/> Former patient | <input type="checkbox"/> Spouse/significant other of patient |
| <input type="checkbox"/> Community member (unaffected by cancer) | <input type="checkbox"/> Other:_____    |  |

**Cancer/Medical Information (please answer t**

**Type of Cancer** \_\_\_\_\_ None

*Please answer following cancer-related questions if applicable*

**Date of diagnosis** \_\_\_\_\_ (month, year)

**Oncologist(s)** (please 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. Newman    | <input type="checkbox"/> Dr. Abate     | <input type="checkbox"/> Dr. Taguchi      | <input type="checkbox"/> Dr. Gupta |
| <input type="checkbox"/> Dr. Ray     | <input type="checkbox"/> Dr. Rosenblum | <input type="checkbox"/> Dr. Walker    | <input type="checkbox"/> Other:_____      |                                    |

**Type of Treatment** (please check all that apply):

- Surgery   Radiation   Chemotherapy   Other: \_\_\_\_\_

**Currently in treatment?**   Yes   No   If no, date of last treatment (month, year)\_\_\_\_\_

**Other Health Information** (please check all that apply):

Please check if you have any of the following medical or physical conditions/limitations:

- heart problems                      diabetes                      high blood pressure                      lymphedema
- shortness of breath                      back or joint pain                      hip or knee replacement                      lightheadedness or fainting
- history of fractures                      numbness, tingling in hands/feet                      balance problems
- other: \_\_\_\_\_

\*\*\*Please note that all of our programs are designed for your comfort and enjoyment. 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, we encourage you to inform the instructor and, if necessary, you may leave at any time. If there are circumstances or accommodations we could make so that your participation in our Wellness Program is both comfortable and enjoyable, please use the dotted line below for any comments or suggestions you have.

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**Informed Consent**

I hereby release and discharge the Cancer Center of Santa Barbara, the Wellness Program staff and all other participating agencies from all injuries or damages suffered by me as a result of my voluntary participation in the Cancer Center of Santa Barbara Wellness Program activities. I agree that the Cancer Center, the Wellness Program staff and all participating agencies are under no obligation to provide physical examination or other evidence of my fitness or ability to participate in such activities, these being my sole responsibility. I also understand that my participation in these programs does not substitute for medical care or psychosocial counseling/support.

**Date** \_\_\_\_\_                      **Signature** \_\_\_\_\_