**INTAKE INFORMATION**

**Please fill out completely. The information on this form is kept confidential.**

**Today's Date:____/_____/_____**

**CHECK ONE:**

☐ I have a serious physical or chronic illness

**OR**

☐ I am a primary caregiver of a family member or loved one with a serious or chronic physical illness

Their name ___________________________________

Relationship __________________________________

Your Name: Last ____________________________ First_______________________ MI______

Birth date_____/_____/_______ Age: ________ Sex: Female ____ Male ____

Name of Spouse/Partner: ___________________________________________________________

Home Address:_________________________________________

City: _________________________________ State: _____ Zip:__________

County (circle one):

Jackson Johnson Wyandotte Cass Platte Douglas Clay Leavenworth

Other___________________________

E-mail Address: ___________________________________________________________________

Phones: Home: _________________ Cell: ___________________ Work: __________________

Employer (most recent or current): ___________________________________________________

Spouse's/Partner's Employer: ________________________________________________________

Emergency Contact:__________________________ Emergency Phone:_____________________

Preferred Hospital (in case of emergency): __________________________________

Health Insurance Provider: _________________________________________________

Name of Physician(s): _____________________________________________________________

**PLEASE CONTINUE ON OTHER SIDE →**

**PLEASE INDICATE YOUR DIAGNOSIS BELOW.**

**If you are a supporter please indicate the diagnosis of the person you are supporting.**

***Check all that apply (be sure to indicate the "Date of diagnosis"):***

☐ **Cancer** **Date of diagnosis__________________** **Has your Cancer metastasized?** ___Yes ___No

___ Brain ___ Breast ___ Cervical ___ Colo – Rectal
___ Esophageal/Gastric ___ Head/Neck ___ Kidney ___ Leukemia
___ Liver ___ Lung & Bronchus ___ Lymphoma ___ Melanoma
___ Multiple Myeloma ___ Ovarian ___ Pancreatic
___ Prostate ___ Uterine ___ Urinary/Bladder
___Other Site: ___________________________________

☐ **Autoimmune Disease** **Date of diagnosis__________________**

___ Rheumatoid Arthritis ___ Lupus ___ Lyme Disease ___ Fibromyalgia
___ Celiac Disease ___ Other: ___________________________________

☐ **Respiratory** **Date of diagnosis__________________**

___ COP ___ Emphysema ___ Acute Asthma Attacks
___ Other ___________________________________

☐ **Heart Disease/Stroke/Circulatory** **Date of diagnosis__________________**

___ Congestive Heart Failure ___ Stroke/CVA ___ Myocardial Infarction
___ Treated High Blood Pressure ___ Other ___________________________________

☐ **Neurological** **Date of diagnosis__________________**

___ Parkinson's ___ MS ___ Essential Tremor ___ ALS ___ Epilepsy
___ Trigeminal Neuralgia ___ Alzheimer's Disease/Dementia ___ Myasthenia Gravis
___ Diagnosed & Treated Migraine Headaches ___ Other: ___________________________________

☐ **Gastrointestinal** **Date of diagnosis__________________**

___ Crohn's Disease ___ Inflammatory Bowel Disease ___ Irritable Bowel Syndrome
___ Other ___________________________________

☐ **Endocrinology** **Date of diagnosis__________________**

___ Diabetes Type I ___ Diabetes Type II ___ Thyroid disorder
___ Other _____________________________

☐ **Eye Disorders:** **Date of diagnosis__________________**

___ Glaucoma ___ Macular Degeneration ___ Other: ___________________________________

☐ **Immune Deficiency Disease** **Date of diagnosis__________________**

___ HIV ___ AIDS ___ Other ________________________________

☐ **Kidney Disease** **Date of diagnosis__________________**

___ Polycystic Kidney Disease ___ Dialysis Treatment
___ Other: ____________________________

☐ **Liver Disease** **Date of diagnosis__________________**

___ Hepatitis C ___ Other ____________________________

☐ **General Muscular/Skeletal** **Date of diagnosis__________________**

___ Treated Osteoporosis ___ Chronic Pain ___ Other ____________________________

# DEMOGRAPHICS

## Turning Point: The Center for Hope and Healing

**Today's date:** ____/____/____

**Last Name:** ________________________________ **First** ____________________________ **MI** _____

**Phone number**:_______________________________ **ZIP Code**: _____________

**Email**_________________________________________________________________

**Your age:** ____ **Date of Birth**: ____/____/____ ☐ **Male** ☐ **Female**

**CHECK ONE:**

☐ I have a serious physical or chronic illness

**OR**

☐ I am a primary caregiver of a family member or loved one with a serious or chronic physical illness

________________________________________________________________________

**What is the serious or chronic illness:** (Your illness **or** the person you are supporting):

☐ Cancer ☐ Parkinson's ☐ MS ☐ Diabetes ☐ Stroke ☐ Heart disease

Other (please specify)__________________________

**Date of the Initial Diagnosis**: ____________

**Your race:**

☐ African American ☐ Asian ☐ Caucasian/white ☐ Hispanic/Latino ☐ Native American

Other_________________________

**Your marital Status:**

☐ Single/Never Married ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

**Do you have health insurance?** Yes____ No____ Medicare____ Medicaid____

**Does your health insurance cover most of your medical expenses?** Yes____ No____

**Approximately what percent of your income is spent on medical expenses? (circle one)**

0 - 10% 25% 50% > 50%

**Your county of residence:** Cass____ Clay____ Jackson____ Johnson____ Platte____ Wyandotte____ Other________________________

**PLEASE CONTINUE ON OTHER SIDE →**

**Your employment Status**:

☐ Part-time ☐ Full-time ☐ Retired ☐ Homemaker ☐ Disability ☐ Unemployed

**Did YOU have employment problems after the diagnosis**: ☐ None ☐ Moderate ☐ Severe (lost job)

**Your profession**: ________________________________________

**Highest level of education you have completed**:

☐ Did not attend school ☐ 8th grade ☐ Graduated from high school

☐ Some college ☐ Graduated from college ☐ Some graduate school ☐ Completed graduate school

**Income level**: ☐ $0-20,000 ☐$20,000-40,000 ☐ $40,000-60,000 ☐ $60,000-80,000

☐ $80,000-100,000 ☐ $100,000+

**How many household members are supported by the above income?**________

**Children living at home**: Y N

**Number of children in the household**_________ **their ages?**______________________

**What hospital(s) or treatment center(s) do YOU visit? ( please circle all that apply)**

Centerpoint Hospital Children's Mercy Hospital KU Cancer Centers (any location)

KC Care Clinic KU Hospital/Medical Center Lee's Medical Center

Liberty Hospital Menorah Medical Center North Kansas City Hospital

Olathe Medical Center Overland Park Regional Providence Medical Center

Research Medical Center (any location) Shawnee Mission Medical Center

St. Joseph/St. Mary's Heath Center St. Luke's Health System (any location)

Truman Medical Center (any location) Veterans Hospital

Other__________________________________________________

**If you were referred to Turning Point by a health care provider who was it and where are they located?**

Doctor (name) ________________________________ Location ________________________________

Nurse (name)_________________________________ Location ________________________________

Case Manager (name) __________________________ Location ________________________________

Social Worker (name) __________________________ Location ________________________________

Other (name & job title)__________________________ Location ________________________________

**How did you hear about Turning Point?**

Family Member____ Friend____ Doctor's office____ Hospital/Treatment Center____

Health Fair____ Single Disease Organization____ Church____ Library____

School____ Internet____ Support Group____ Mailing____

Other_______________________________

Turning Point Representative____ Can you give the person's name?________________________

# Turning Point: The Center for Hope and Healing

**Last Name:** ________________________________ **First** _________________________ **MI** ____

**Today's Date:**___/____/____ ☐ **Male** ☐ **Female** **Date of Birth**: ____/____/____

**Phone number**:___________________________ **ZIP Code**: _______________

**Email**_____________________________________________________________

| **In the past 7 days...** | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| I felt fearful | ☐ | ☐ | ☐ | ☐ | ☐ |
| I found it hard to focus on anything other than my anxiety | ☐ | ☐ | ☐ | ☐ | ☐ |
| My worries overwhelmed me | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt uneasy | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt nervous | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt like I needed help for my anxiety | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt anxious | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt tense | ☐ | ☐ | ☐ | ☐ | ☐ |
| **In the past 7 days...** | Never | Rarely | Sometimes | Often | Always |
| I felt worthless | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt helpless | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt depressed | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt hopeless | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt like a failure | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt unhappy | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt that I had nothing to look forward to | ☐ | ☐ | ☐ | ☐ | ☐ |
| I felt that nothing could cheer me up | ☐ | ☐ | ☐ | ☐ | ☐ |