TURNING POINT
The Center for Hope and Healing
A program of
THE UNIVERSITY OF KANSAS HOSPITAL

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 <u>YOU</u> 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 *Person with Diagnosis*

Last Name: _____ First _____ MI ____

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

Phone number:_____ ZIP Code: _____

Email_____

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
Are you able to run errands and shop?	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐
In the past 7 days...	Never	Rarely	Sometimes	Often	Always
I felt worthless	☐	☐	☐	☐	☐
I felt helpless	☐	☐	☐	☐	☐
I felt depressed	☐	☐	☐	☐	☐
I felt hopeless	☐	☐	☐	☐	☐
During the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
I feel fatigued	☐	☐	☐	☐	☐
I have trouble starting things because I am tired	☐	☐	☐	☐	☐
How run-down did you feel on average?	☐	☐	☐	☐	☐
How fatigued were you on average?	☐	☐	☐	☐	☐
In the past 7 days...	Very poor	Poor	Fair	Good	Very good
My sleep quality was	☐	☐	☐	☐	☐
In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was refreshing	☐	☐	☐	☐	☐
In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
I had a problem with my sleep	☐	☐	☐	☐	☐
I had difficulty falling asleep	☐	☐	☐	☐	☐
In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
I am satisfied with how much work I can do (include work at home)	☐	☐	☐	☐	☐
I am satisfied with my ability to work (include work at home)	☐	☐	☐	☐	☐
I am satisfied with my ability to do regular personal and household responsibilities	☐	☐	☐	☐	☐
I am satisfied with my ability to perform my daily routines	☐	☐	☐	☐	☐
In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
How much did pain interfere with your day to day activities?	☐	☐	☐	☐	☐
How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
How much did pain interfere with your household chores?	☐	☐	☐	☐	☐
In the past 7 days...					
How would you rate your pain on average	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
	No Pain				**Worst Imaginable pain**