Today's Date:____/_____/_____

TURNING POINT
THE UNIVERSITY OF KANSAS HEALTH SYSTEM

CHECK ONE:

☐ I have a serious or chronic physical illness

OR

☐ I am a supporter 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:** ____

Gender: ☐ Female ☐ Male ☐ Prefer to self-describe_____

Name of Spouse/Partner: _____

Home Address: _____

City: _____ **State:**_____ **Zip:**_____ **County:**_____

E-mail Address: _____

Phones: Home: _____ Cell: _____ Work: _____

Emergency Contact:_____ **Emergency Phone:**_____

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

Your employment status: ☐ Part-time ☐ Full-time ☐ Retired ☐ Homemaker ☐ Disability ☐ Unemployed

Your profession: _____

Highest level of education you have completed: ☐ Did not attend school ☐ 8th grade ☐ 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? _____

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

☐ Advent Health Shawnee Mission ☐ Centerpoint Medical Center ☐ Children's Mercy
☐ Kansas City VA Medical Center ☐ KU Cancer Center (any location) ☐ KC Care Health Center
☐ KU Health System/Medical Center ☐ Lee's Summit Medical Center ☐ Liberty Hospital
☐ Menorah Medical Center ☐ North Kansas City Hospital ☐ Olathe Medical Center
☐ Overland Park Regional ☐ Providence Medical Center ☐ Research Medical Center
☐ St. Joseph Medical Center ☐ St. Luke's Health System ☐ Truman Medical Center
☐ Other_____

How did you hear about Turning Point?

☐ Family Member ☐ Friend ☐ Doctor's office ☐ Hospital/Treatment Center ☐ Health Fair
☐ Church ☐ Library ☐ School ☐ Internet ☐ Support Group
☐ Mailing ☐ Other_____

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: _____

☐ **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 ☐ Multiple Sclerosis ☐ 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 _____

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**

Turning Point

The University of Kansas Health System

Mission Statement

Turning Point empowers and transforms the body, mind and spirit of individuals who are living with a serious or chronic physical illness and their family and friends. We provide innovative, educational services and tools to inspire people to take charge of their illness and live their life to its fullest.
We enhance the well-being of individuals, families and the communities we serve through resilience education and prevention resources.

Registration & Attendance

Pre-registration is necessary and required.
Unless otherwise stated, please call 913-574-0900 to register for a program.

- Register early, some classes are limited in size.
- Please keep your commitments to attend a class when you are registered so that we do not commit a facilitator for an empty class. Some of our programs have waiting lists, so if you can't attend, please call us so that we can give your spot to another person.

- Please be on time. It is recommended that you arrive 10 minutes before the scheduled time, especially for exercise programs.
- We reserve the right to cancel a class due to low enrollment.

Personal Property

Please respect Turning Point property and the privacy of our staff. Feel free to help yourself to a cup of coffee or tea. Items in our kitchen cabinets and in the refrigerator however, are not for general use. Please alert us to any spills so that we can clean them promptly. Private staff offices and computers are for staff use only.

Statement of Non-Discrimination

Turning Point programs and services are provided to individuals living with cancer and other serious or chronic physical illness and their family members and friends without regard to gender, age, religion, race, ethnicity, economic status or sexual orientation.

Illness

When you are ill with cold or flu, strep throat, contagious seasonal illness etc. - we request that you stay home. Many of our participants have compromised health issues and it could be very detrimental if they contracted a cold or the flu. We realize this may mean you might miss one or two of the sessions which are so important to you. However, we strongly encourage people with a contagious illness to stay home, take care, get well and then return to us when you are feeling better.

Confidentiality

We maintain confidentiality at all times in all areas having to do with groups and our participants. "What is said here – stays here." Who attends the group is also confidential. You are certainly free to share with others the concepts, feelings, issues and skills that are discussed and learned in the group but no information that could be used to identify group members is to be shared outside of the group. (names, professions, diagnoses, etc. – anything that could potentially disclose the group member's identity, unless you have specific permission from that person to do so).

Perfume/Smoking

Many participants at Turning Point have sensitivities to odors, due to their treatments or medications.
We ask that you not wear perfume or perfumed lotions and that you not smoke just prior to classes. Your cooperation is much appreciated as it greatly affects the well being of our participants.

Weather Policy

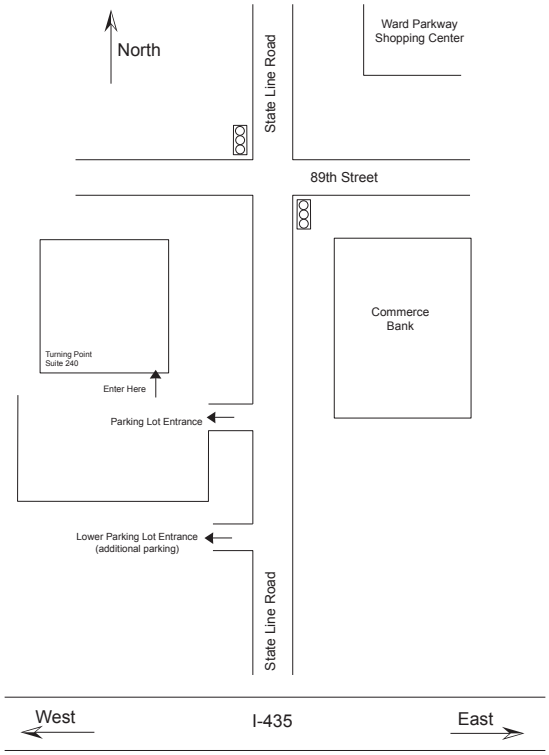
Please note that when Shawnee Mission School District USD 512 is closed due to inclement weather – Turning Point programs are cancelled.

Privacy

Protecting your privacy is important to us.
We do not sell or share our mailing list to other parties. We strive to maintain complete and accurate information. If you move or change your phone number or e-mail, please let us know. If you would like to be removed from our mailing list, or e-mail contact list, call us at 913-574-0900 or e-mail turningpoint@kumc.edu.

Directions & Parking

Turning Point is located in an office building on the southwest corner of 89th and State Line Road.
The sign out front says 8900 Offices.
The entrance to the parking lot is south of 89th Street. Enter through the door on the southeast corner of the building (you will enter on the second floor) turn left and go to Suite 240.
Additional parking is available in the lower lot farther south on State Line. On the lower level enter through the sliding glass doors and take the stairs or the elevator to the second floor. Handicapped parking is available in both lots.



Contact Information

Turning Point: The Center for Hope and Healing
8900 State Line Rd., Suite 240
Leawood, KS 66206
913-574-0900 phone • 913-574-0901 fax
www.turningpointkc.org

Donations: Ways to say Thanks

Turning Point programs are presented by the best facilitators in the region and we typically pay them to share their expertise with you.
We are supported entirely by donations.
Please consider making a contribution to Turning Point and encourage others to do the same.
Your gift is fully tax-deductible and will help us maintain our high level of programs and service to people facing the challenges posed by serious or chronic physical illness.
If you have questions about making a donation, please call or e-mail Jeanne Hansey at 913-588-2800 or jbrown1@kumc.edu.

Office Hours & Holidays

Turning Point office hours are generally:
Monday - Thursday 8:30 am – 5:00 pm
8:30 am - 12:00 noon on Fridays.
Observed Holidays include:
New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and the day after Thanksgiving, Christmas Day.
Programs are not held between Christmas and New Year's Day.

Turning Point Staff

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