Today's Date: _____

OSF Healing Pathways Confidential
Programming Intake and Health History Form

Name: (Please Print)_____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____)_____ Cell Phone: (____)_____ E-Mail: _____

Gender: _____ Race: _____ Cancer Survivor: _____ Caregiver: _____

Emergency Contact: Name_____ Phone: _____

How did you find out about us? _____

Survivors

Date of Cancer Diagnosis: _____Diagnosis:_____

____ Pre-treatment ____ In treatment ____ Post-treatment

Oncologist: _____Surgeon: _____

Hospital/Clinic: _____

Has there been a recurrence? _____ If yes, when: _____

Surgeries and Approximate Dates: _____

_____

Are you currently under the care of a health care practitioner? _____Yes _____No

If yes, specify purpose: _____

Chemotherapy: Mo./Yr. Ended _____ or Continuing _____

Radiation: Mo./Yr. Ended _____ or Continuing _____

Hormonal or Pharmaceutical Therapy: Approx. Date Ended_____ Continuing_____

Do you have a port or medical appliance of any kind? ____ If yes, please describe: _____

Neuropathy_____ If yes, where? _____ Lymphedema_____ If yes, where? _____

Pain_____ If yes, please describe:_____

Survivors & Caregivers

Depression_____ Anxiety_____ Insomnia_____ Fatigue_____

Are you aware of any limitations on activity that you have? If yes, please describe:

_____

Injuries/accidents/illnesses still affecting you? _____

Is there anything additional that the instructors or therapist should know about you?

_____

_____

I have read and agree to the following terms prior to receiving services:

- I understand that I may receive these services for up to two (2) years post-treatment.
- I affirm that I have completed this form to the best of my knowledge and ability. I understand that any information provided is for safety purposes and will be kept strictly confidential. I agree to inform the instructor and/or therapist of any changes in my health and medical condition. I understand that there shall be no liability on the part of the instructor, therapist or OSF Healing Pathways Cancer Resource Center should I fail to do so.
- I understand that an instructor or therapist is not qualified to diagnose, prescribe or treat illness, disease or any physical or mental disorders. I understand that massage therapy/body work may be contraindicated for specific medical conditions or symptoms.
- I acknowledge that I am responsible for consulting a health care practitioner for any physical ailments. I understand that the therapist or instructor will need a release form from my practitioner before services can be provided.
- I understand that if I am late for my appointment, my session may be shortened or rescheduled due to time restraints. I agree to give a 24-hour notice for a scheduled appointment that I cannot keep.
- I, the undersigned, acknowledge that I have voluntarily chosen to participate in the classes/programs/services (hereinafter collectively known as "Services") offered by OSF Healing Pathways Cancer Resource Center. I acknowledge and agree that I am doing so at my own risk and that my health and safety with respect to such Services is my sole responsibility. In exchange for receiving such Services, I, for myself and on behalf of my heirs, executors administrators and personal representatives, hereby waive, release, discharge and hold harmless OSF Healing Pathways Cancer Resource Center, its officers, directors, employees, independent contractors and agents from any and all liability for any and all injuries, damages, or claims relating to or resulting from my receipt of the Services, now or in the future, foreseen and unforeseen. I acknowledge that I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Participant's Name (please print): _____

Participant's Signature: _____Date: _____

Or Parent/Guardian Signature:_____ Date: _____

Photo Release and Waiver: _____ I hereby give permission to OSF Healing Pathways-CRC to print and publish for public relations purposes my photo should one be taken of me while at the center or the organizations special events. _____I do not give permission to have my photo taken or used.

Participant Signature: _____ Date: _____