



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: _____
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Immune Deficiency Disease Date of diagnosis _____

___ HIV	___ AIDS	___ Other _____
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Kidney Disease Date of diagnosis _____

___ Polycystic Kidney Disease	___ Dialysis Treatment
___ Other: _____	

Liver Disease Date of diagnosis _____

___ Hepatitis C	___ Other _____
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General Muscular/Skeletal Date of diagnosis _____

___ Treated Osteoporosis	___ Chronic Pain	___ Other _____
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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? _____

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Are you able to go up and down stairs at a normal pace?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Are you able to go for a walk of at least 15 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Are you able to run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
In the past 7 days...	Never	Rarely	Sometimes	Often	Always						
I felt fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I found it hard to focus on anything other than my anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
My worries overwhelmed me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I felt uneasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
In the past 7 days...	Never	Rarely	Sometimes	Often	Always						
I felt worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I felt helpless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I felt depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I felt hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
During the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much						
I feel fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I have trouble starting things because I am tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
How run-down did you feel on average?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
How fatigued were you on average?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
In the past 7 days...	Very poor	Poor	Fair	Good	Very good						
My sleep quality was	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much						
My sleep was refreshing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much						
I had a problem with my sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I had difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I am satisfied with my ability to work (include work at home)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I am satisfied with my ability to do regular personal and household responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
I am satisfied with my ability to perform my daily routines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
How much did pain interfere with work around the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
How much did pain interfere with your ability to participate in social activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
How much did pain interfere with your household chores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
In the past 7 days...											
How would you rate your pain on average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	5	6	7	8	9	10
	No Pain					Worst Imaginable pain					