

# Wellspring Niagara Membership Registration Form

**Please select which Centre you attend: Thorold  Stevensville  Both**

1. Today's date: \_\_\_\_\_  
Month / Day / Year
2. Title:  Mr.  Mrs.  Ms.  Dr.  Other: \_\_\_\_\_  
Name: \_\_\_\_\_
3. Address \_\_\_\_\_  
Street \_\_\_\_\_  
Town/City \_\_\_\_\_ Province \_\_\_\_\_  
Postal Code \_\_\_\_\_
4. Phone: (\_\_\_\_) \_\_\_\_\_ (home) (\_\_\_\_) \_\_\_\_\_ (cell)  
(\_\_\_\_) \_\_\_\_\_ (bus.) E-mai: \_\_\_\_\_
5. I prefer to receive Wellspring information and updates via:  
 Email  Regular Mail  I prefer to not receive updates

Wellspring is dedicated to providing members with the best possible programs and services. To do so, it is very helpful for us to have certain information about who is registering with Wellspring. We would very much appreciate your assistance by completing the following questions about yourself. **All responses are strictly confidential.** However, if you do not wish to answer these questions, we certainly understand and it will in no way affect your access to, or participation in, any of Wellspring's programs or services.  
Thank you for your cooperation.

6. You are registering with Wellspring as a (check one):
- Cancer patient
  - Caregiver: specify your relation to cancer patient (please check one):
    - Wife
    - Husband
    - Daughter
    - Son
    - Mother
    - Father
    - Partner
    - Friend
    - Other → specify: \_\_\_\_\_
7. If you are a cancer patient, are any of your family members also registered at Wellspring?  
 No  Yes → How many? \_\_\_\_\_
8. If you are not a cancer patient, are you providing emotional support to a patient? Yes  No   
Yes → Is this person a member of Wellspring? Yes  No

Please turn over...

9. Your Date of Birth: \_\_\_\_\_  
Month / Day / Year

10. Your Gender:  Male  Female

11. What is the highest grade or level of education you have ever completed (check one)?

- No schooling
- Some elementary (Grade 8)
- Graduated elementary school
- Some high school (grade 9 to 12)
- Graduated high school
- Some trade/vocational training
- Graduated trade/vocational training
- Some college (community college, technical college)
- Graduated college
- Some university
- Graduated university (Bachelor's degree)
- Postgraduate or professional degree (e.g., PhD, MBA, MD, LLB)
- Other education or training → specify: \_\_\_\_\_

12. Many Canadians come from different ethnic or cultural backgrounds (such as First Nations, German, Chinese, Canadian, etc). To which ethnic or cultural group or groups do you feel you belong?

Specify: \_\_\_\_\_

13. What language do you usually speak in your home (e.g., Cantonese, French, Italian, English, etc)?

Specify: \_\_\_\_\_

14. In what language would you prefer to receive Wellspring services (e.g., Italian, French, English, etc.)?

Specify: \_\_\_\_\_

15. You initially heard of Wellspring through (check one):

- A Wellspring member
- Magazine/newspaper/television
- Doctor's referral
- Referral from hospital staff (e.g., nurse, social worker) → specify: \_\_\_\_\_
- Wellspring literature in doctor's office, hospital, clinic, etc.
- Other → specify: \_\_\_\_\_

If you are *a cancer patient*, please answer questions 16 - 22.

If you are *not a cancer patient*, please skip to question 22.

The next three questions ask about different types of treatment for your cancer. Please read these questions carefully before responding.

16. a) Date of 1st diagnosis: \_\_\_\_\_  
Month / Year
- b) Type(s) of cancer: \_\_\_\_\_
- c) What type(s) of treatment have you received or are scheduled to receive (check all that apply):
- |   |   |
|---|---|
| <input type="checkbox"/> Surgery                                  | <input type="checkbox"/> Hormone Treatments     |
| <input type="checkbox"/> Chemotherapy                             | <input type="checkbox"/> Transplant             |
| <input type="checkbox"/> Radiation                                | <input type="checkbox"/> Other → specify: _____ |
| <input type="checkbox"/> None of the above (see also Question 17) |   |

17. Have you experienced any recurrences (check one)?

- No → Go to Question 18
- Yes → Complete parts a) to c) below

- a) Date(s) of recurrence(s): \_\_\_\_\_  
Month(s) / Year(s)
- b) Type(s) of recurrence(s): \_\_\_\_\_
- c) What type(s) of treatment(s) for your recurrence(s) have you received or are scheduled to receive (check all that apply)?
- |   |   |
|---|---|
| <input type="checkbox"/> Surgery                                  | <input type="checkbox"/> Hormone Treatments     |
| <input type="checkbox"/> Chemotherapy                             | <input type="checkbox"/> Transplant             |
| <input type="checkbox"/> Radiation                                | <input type="checkbox"/> Other → specify: _____ |
| <input type="checkbox"/> None of the above (see also Question 18) |   |

18. Many cancer patients receive additional treatments to those provided by their cancer specialist. Which of the following treatments have you received for your cancer (check all that apply)?

- Herbal Therapies (e.g., essiac, ginseng)
- Vitamins (e.g., beta-carotene, Vitamin C)
- Acupuncture
- Immune System Boosters
- Naturopathy
- Homeopathy
- Traditional Chinese Medicine
- Shark Cartilage
- Physical Therapies (e.g., chiropractic, massage)
- Expressive Art Therapies (e.g., art, music)
- Psychological Therapies (e.g., imagery, psychotherapy)
- Diet (e.g., Gerson, grape cure, macrobiotics)
- Other → specify: \_\_\_\_\_
- None of the above (see also questions 19 and 20)

19. What is the name of your family doctor? \_\_\_\_\_

20. What is the name of your cancer specialist? \_\_\_\_\_

Please turn over...

21. At which hospital are you receiving treatment? (please check all that apply)

- Hotel Dieu
- St. Catharines General Hospital
- The Juravinski Cancer Centre
- Mount Sinai Hospital
- Princess Margaret Hospital
- St. Joseph's Hospital
- Sunnybrook and Women's College Health Sciences Centre
- Other (please specify): \_\_\_\_\_

22. What do you hope to gain from joining Wellspring (check all that apply)?:

- Medical information on cancer and/or treatment options
- Emotional support
- Coping skills \_\_\_\_\_
- Information on doctors, hospitals or other medical resources
- Information about alternative treatments
- Communication skills to improve sharing information about cancer with others
- Social Support
- Caregiver Support
- To Volunteer
- Energy work ie Reiki and Therapeutic Touch
- Networking
- Other → specify: \_\_\_\_\_

Wellspring conducts internal evaluation of its programs on an on-going basis as part of its commitment to program quality. Would you be willing to receive information from Wellspring about its evaluation activities?

**Yes**       **No**

Wellspring also participates in research to understand better supportive care needs and issues related to cancer. Would you be willing to receive information from Wellspring about its research activities?

**Yes**       **No**

Thank you! Please return this form to Wellspring Niagara— in person, by mail, or by fax.  
Wellspring Niagara, 3250 Schmon Parkway, Unit 3, Thorold, ON L2V 4Y6  
Phone Number: (905) 684-7619 ● Fax Number: (905) 684-1262 ● [www.wellspringniagara.ca](http://www.wellspringniagara.ca)