Adolescent (Ages 12-18) Member Application

For office use only:					
Copied	Initial_____	Date_____	M&B	Initial_____	Date_____
LGL	Initial_____	Date_____	CC	Initial_____	Date_____

Please complete this form in its entirety. The information below will be held in confidence and for the use of Wellness House staff members only. This information helps our organization manage our programs, as well as apply for grants to continue funding our operations.

Adolescent Member Information

Name (First & Last): _____ Date of Birth:_____

Preferred Pronouns:_____ Gender:_____ Race/Ethnicity:_____

Religious Preference:_____

Parent/Guardian Contact Information

Name (First & Last): _____ Date of Birth:_____

Preferred Pronouns:_____ Gender:_____ Race/Ethnicity:_____

Religious Preference:_____ Marital Status:_____ Military Status:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Email:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Preferred Contact Number: ◉ Home ○ Cell ○ Work

Emergency Contact (First & Last Name):_____Phone:_____Relationship:_____

How did you hear about Wellness House of Annapolis?_____

Did someone refer you? If yes, please list here. (First & Last Name):_____

Do you have any children or family members who may benefit from our programs and services?

Name(s) and Age(s) of family members:_____

Medical Information

Name of person with cancer (First & Last): _____

Treatment Status: ☐ Active Treatment ☐ Survivor ☐ Thriver

Type of Cancer:_____ Stage of Cancer:_____ Diagnosis Date: _____

Oncologist Name (First & Last):_____

Relationship to person with cancer:_____

I have read and understand all member policies.

_____ _____

Signature of Adult Member (age 18 and above) **Date**

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Questionnaire (to be completed by Adolescent)

1. **What kind of social media do you use?**

2. **What have you been told about the cancer diagnosis?**

3. **What are your thoughts about the cancer diagnosis?**

4. **Since the diagnosis, are you still involved in the same activities? How has your life changed?**

5. **Have you seen a counselor (either private or in school) in the past?**

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Questionnaire (to be completed by Adolescent)

6. **Do you have any allergies or take any medications? Please list them out here.**

7. **What are your strengths?**

8. **What are your goals for the future?**

9. **What is your biggest need right now?**

10. **What do you hope to gain from participating in our programs?**

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Program Waiver Agreement

I, _____, understand the programs at Wellness House of Annapolis which include but are not limited to Healing Touch, Massage, Reiki, Reflexology, Counseling, Support Groups, Mindfulness, Meditation, Educational and Nutrition Seminars, Exercise Programs, and Social Activities, are offered as complimentary services to those experiencing cancer either as a patient or a caregiver. Social and special interest programs such as Book Club, Healing Music, Support Groups, Meditation and Mindfulness classes, Therapeutic Art, and Member Gatherings are offered as a source of stress relief, peer companionship, support and relaxation. I understand these services are not a substitute for medical treatment or the advice of my medical professional and that the teachers, practitioners, or participants do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, or interfere with the treatment of a licensed medical professional.

_____I understand that Healing Touch and Reiki are simple, gentle, complimentary energy based approaches to health and healing that can assist my body in its natural ability to heal. I understand that the practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional.

_____I understand that I should seek approval from my physician prior to receiving Massage at Wellness House of Annapolis to ensure that my current medical conditions do not contraindicate massage.

_____I understand the exercise programs which include but are not limited to Tai-Chi, Pilates and Yoga are offered by trained and/or licensed professionals to be beneficial to my health and well-being. I understand the class leaders do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, or interfere with the treatment of a licensed medical professional. As with all exercise programs, I understand that I should seek the approval of my physician before beginning the practice.

_____I understand that nutrition and other educational seminars are offered periodically by Wellness House in areas of interest to our membership. Presenters are invited by Wellness House because of their special knowledge or expertise, but under no circumstances do they diagnose conditions, prescribe or perform medical treatment, prescribe substances, or interfere with the treatment of a licensed medical professional.

_____I affirm that I alone am responsible to decide whether to participate, and to what degree to participate, in the programs offered by Wellness House of Annapolis. I hereby agree to irrevocably release and waive any claims that I have now or may hereafter have against Wellness House of Annapolis and its staff, practitioners and volunteers.

_____Limitations of confidentiality: If there is a threat to your life or others, this information cannot be kept confidential, and our counselors are mandated to report relevant information to the authorities. Limitations of our confidentiality include threats against yourself or another person, physical or sexual abuse or neglect. If you are experiencing a mental health emergency, support is always available, please call the Anne Arundel County Warm Line at 410-768-5522 or dial 9-1-1.

_____ _____

Signature of Adult Member (age 18 and above) **Date**