# COUNCELING INTAKE FORM

Today's Date: ______/______/______

## SECTION A: PERSONAL INFORMATION (PLEASE FILL IN ALL SPACES TO QUALIFY FOR PROGRAM)

Name: ____________________________________ Date of Birth: _____/______/______

Home Address (Street, City, State, Zip): ______________________________________________________

Phone: ____________________________________ Email: ___________________________________
Home Mobile Work Family Friend

Gender: Woman Man Non-binary Prefer to self-describe: ___________________________

Are you Hispanic/Latina? No, not Hispanic / Latina Yes, Hispanic / Latina

What race best describes you? American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other ______________________

Are you currently Employed? Yes No

What type of insurance do you have?
No insurance Public insurance (Tenncare/Medicaid, VA, Medicare) Private Insurance (HMO, PPO)
If yes, insurance name: ___________________________________________________________________

What is your monthly/annual household income? $_____________

How many individuals live in your home? ____________

## SECTION B: HOW CAN WE HELP YOU AND MISCELLANEOUS INFORMATION

Please select the answer that best describes you:
Cancer Patient/Survivor Cancer Caregiver

Have you ever received counseling funded by West Cancer Foundation?
Yes No If yes, when: ________________________________________________________________

Please select the type of appointment you prefer:
In-Person Visit Virtual/Tele Visit

Do you have a preferred day/time of the week that works best for you?

__________________________________________________________________________________________

Which location works best for you?

Preferred Location:

2673 Yale Ave- Binghampton

Other Locations include:

2100 and 2150 Whitney- Frayser

1200 Peabody Ave- Downtown

2579 Douglass- Orange Mound

3628 Summer Ave- Grahamwood

3810 Winchester- Oakhaven

I may require assistance with transportation so that I can make my appointment.

Referral Source/Location: ____________________________________________________________

Referring Physician: __________________________________________________________________

Referral Source/Physician Contact Number: _______________________________________________

Please fax all pages to 901-786-6186.

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For WCF Office Use Only

WCF Staff ________________________________ Contact Number __________________________

Notes _________________________________________________________________________________

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