The Survivors Health Project Membership Form

Thank you for your interest in becoming a member of The Survivors Health Project. Your responses will be treated confidentially.

Date____ **Email** ___________________________________

Name ____**Pronouns**________________________________

Best Phone to Reach You ____

Your Address ____

Your County ____

Who is your Emergency Contact Person?____

Emergency Contact Person's Phone ____

How did you find out about The Survivors Health Project? ____________________________________

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Why are you interested in participating in The Survivors Health Project? ________________________

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Are you a survivor? ☐**Yes** ☐**No** **If yes, please indicate all that apply:**

☐childhood sexual abuse ☐sexual violence ☐trafficking
☐sexual assault ☐sexual harassment ☐teen dating violence
☐substance abuse ☐mental illness ☐stalking
☐childhood emotional abuse ☐childhood neglect ☐identity abuse
☐ spiritual or cultural violence ☐socio-economic violence ☐gun violence
☐intimate partner violence/domestic violence ☐childhood commercial sexual exploitation
☐other____

____

Are you experiencing a chronic health problem? ☐**NO** ☐**YES (please indicate all that apply):**

☐ arthritis	☐ back pain	☐ carpal tunnel syndrome
☐ chronic fatigue syndrome	☐ chronic pain	☐ endometriosis
☐ depression	☐ fibromyalgia	☐ anxiety
☐ PTSD	☐ lupus	☐ migraines
☐ traumatic brain injury	☐ headaches	☐ vulvodynia
☐ dental problems	☐ chronic stress	☐ body pain/soreness

☐ other____

Please read and answer the questions below.

Have you read The Survivors Health Project Membership Eligibility Requirements document? ☐**Yes** ☐**No**

Have you ever used HopeWorks' crisis services (shelter, clinical therapy, legal, advocacy)? ☐**Yes** ☐**No**

*If yes, when*____

Have you attended any HopeWorks education/self-care and/or support groups? ☐**Yes** ☐**No**

If yes, which one(s): ____

Note: Must Choose at least one support group

Will you attend the ARTiculation health education and support group? ☐**Yes** ☐**No**

Will you attend the Thriving Together mental health awareness and wellbeing support group? ☐**Yes** ☐**No**

Will you attend the LOVED: a survivor self-care circle for Black women ☐**Yes** ☐**No**

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Would you like to use the Wellness Locker? ☐**Yes** ☐**No** ☐**Maybe**

Would you like to use a Wellness Grant? ☐**Yes** ☐**No**

Would you like to attend virtual yoga sessions? ☐**Yes** ☐**No** ☐**Maybe**

Please email your completed form to: **vleatherwood@HopeWorksOfHC.org**

Or mail to:
Vanita Leatherwood, Director of Community Engagement
HopeWorks of Howard County
9770 Patuxent Woods Dr., Suite 300
Columbia, MD 21046