LIVESTRONG® AT THE YMCA INTAKE FORM

PARTICIPANT INFORMATION

Name:		Date (DD/MM/YY): / /
Preferred phone number:	Email:	Preferred contact method: ☐ Phone ☐ Email
Where were you treated?		
Physician name:		

1. **Date of birth** (DD/MM/YY): ____/____/____

2. **Gender:** ☐ Male ☐ Female

3. **Are you Hispanic, Latino/a, or Spanish origin?** [One or more categories may be selected]

   ☐ No, not of Hispanic, Latino/a, or Spanish origin
   ☐ Yes, Mexican, Mexican American, Chicano/a
   ☐ Yes, Puerto Rican
   ☐ Yes, Cuban
   ☐ Yes, Another Hispanic, Latino/a or Spanish origin

4. **What is your race?** [One or more categories may be selected]

   ☐ White
   ☐ Black or African American
   ☐ American Indian or Alaska Native
   ☐ Asian Indian
   ☐ Chinese
   ☐ Filipino
   ☐ Japanese
   ☐ Korean
   ☐ Vietnamese
   ☐ Other Asian
   ☐ Native Hawaiian
   ☐ Guamanian or Chamorro
   ☐ Samoan
   ☐ Other Pacific Islander

5. **How did you learn about the LIVESTRONG® at the YMCA cancer survivorship program?**

   ☐ Y staff member or volunteer
   ☐ A friend or family member or word of mouth
   ☐ A doctor or other health care professional
   ☐ A local or national cancer awareness or support organization or event
   ☐ A mailing or email communication
   ☐ A poster, or flyer or event at the Y
   ☐ A poster or flyer at a cancer or medical center
   ☐ The Y's website
   ☐ LIVESTRONG
   ☐ Media (TV, web, radio, print, etc.)
   ☐ Other (please specify): _____

HEALTH INFORMATION

6. Have you ever had any of the following health problems?

• Pulmonary (lung) problems	☐ Yes	☐ No
• Heart problems or surgery	☐ Yes	☐ No
• Diabetes	☐ Yes	☐ No
• Altered heart rate	☐ Yes	☐ No
• Dizziness or fainting (unrelated to cancer treatment)	☐ Yes	☐ No
• Chest, neck or arm pain	☐ Yes	☐ No
• Pain or cramping in legs while walking	☐ Yes	☐ No
• Short-term weakness on one side of the body	☐ Yes	☐ No
• Elevated blood pressure	☐ Yes	☐ No
• Low blood pressure	☐ Yes	☐ No
• High cholesterol	☐ Yes	☐ No
• Smoker or previous smoker	☐ Yes	☐ No
• Arthritis	☐ Yes	☐ No
• Other (please specify): _____		

6.a If you answered "YES" to any of the above, please describe briefly (255 character limit):

7. Type of Cancer:

☐ Bladder	☐ Leukemia	☐ Melanoma	☐ Other (please specify):
☐ Bone	☐ Liver	☐ Skin (Non Melanoma)	
☐ Brain	☐ Lung	☐ Stomach (Gastric)	
☐ Breast	☐ Lymphoma	☐ Testicular	
☐ Cervical	☐ Myeloma	☐ Thyroid	
☐ Colon and Rectal	☐ Oral	☐ Uterine	
☐ Endometrial	☐ Ovarian		
☐ Esophageal	☐ Pancreatic		
☐ Head and Neck	☐ Prostate		
☐ Kidney (Renal Cell)	☐ Rectal		

8. **Cancer diagnosis date** (MM/YY): ____/____

9. **Surgery?** ☐ Yes ☐ No 9.a. If yes, date of most recent surgery (MM/YY): ____/____

10. **Chemotherapy?** ☐ Yes ☐ No 10.a. If yes, date of last treatment (MM/YY): ____/____

11. **Radiation?** ☐ Yes ☐ No 11.a. If yes, date of last treatment (MM/YY): ____/____

12. **Do you have an implanted port or Central Venous Access Catheter?** ☐ Yes ☐ No

If yes, specify location (50 character limit):

13. **Are you experiencing peripheral neuropathy (i.e. tingling/loss of sensation in your fingers and/or toes)?** ☐ Yes ☐ No

If yes, specify location (50 character limit):

14. **Has the cancer spread to any bones?** ☐ Yes ☐ No

If yes, please describe where (50 character limit):

HEALTH INFORMATION CONTINUED...

15. **Have you had any lymph nodes removed?** ☐ Yes ☐ No

If YES:

15.a. Where have you had lymph node involvement?

☐ Head and Neck ☐ Right Upper Extremity
☐ Left Upper Extremity ☐ Right Lower Extremity
☐ Left Lower Extremity

15.b. Check all that are true:

☐ I have been DIAGNOSED with Lymphedema.
☐ I am currently experiencing STIFFNESS or LOSS OF RANGE OF MOTION in the area that the lymph nodes have been removed.
☐ I am currently experiencing PAIN or DISCOMFORT in the area that the lymph nodes have been removed.

16. **Are there any other major illnesses, injury or issues (physical or psychological) we should be aware of?** ☐ Yes ☐ No

16.a. If yes, please explain (255 character limit):

17. **List current medications, including vitamins and over-the-counter** (If not applicable, record 0):

18. **Describe your health at the present time:** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

PHYSICAL ACTIVITY INFORMATION

19. Do you participate in exercise regularly? ☐ Yes ☐ No

If YES:

19.a Please describe the FREQUENCY of your exercise:

- ☐ Daily
- ☐ 2-6 times a week
- ☐ Once a week
- ☐ Less than once per week
- ☐ Monthly

19.b Please describe the INTENSITY of your exercise:

- ☐ Light
- ☐ Moderate
- ☐ Vigorous

19.c Please list the TYPES of exercise you participate in regularly (255 character limit):

PHYSICAL ACTIVITY INFORMATION CONTINUED...

20. Do you have any physical limitations that restrict your daily living activities or ability to exercise? ☐ Yes ☐ No

20.a If yes, please explain (255 character limit):

21. Are there any other limitations since your cancer diagnosis? ☐ Yes ☐ No

21.a If yes, please explain (255 character limit):

22. Are you working? ☐ Yes ☐ No

If YES:

22.a What is your level of activity at work?

- ☐ Sedentary
- ☐ Light
- ☐ Moderate
- ☐ Vigorous

If NO:

22.b Since when (MM/YY)? _____/_____

23. Describe your past experience with resistance training and aerobic training (255 character limit):

24. What expectations do you have from this program (255 character limit):

25. Do you have any concerns about starting this exercise program (255 character limit):