Association: Branch:

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

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
☐ Left Upper Extremity
☐ Left Lower Extremity
☐ Right Upper Extremity
☐ Right 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:	If NO:
22.a What is your level of activity at work? ☐ Sedentary ☐ Light ☐ Moderate ☐ Vigorous	**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):