Association: Branch:

LIVE**STRONG**® AT THE YMCA INTAKE FORM

PARTICIPANT INFORMATION

Name:		Date (MM/DD/YYYY): / /
Preferred phone number:	Email:	Preferred contact method: ☐ Phone ☐ Email
Address:		
City:	State:	Zip:
Where were you treated?		
Physician name:		
Are you a member of the Y? Circle one: YES / NO / NOT REPORTED		

1. **Date of birth** (MM/DD/YYYY): ____/____/_____.
2. **Gender:** ☐ Male ☐ Female
3. **Are you Hispanic, Latino/a, or Spanish origin?**

   ☐ Yes
   ☐ No
   ☐ Prefer not to answer

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

   ☐ American Indian or Alaska Native
   ☐ Asian
   ☐ Native Hawaiian or Other Pacific Islander
   ☐ Black or African American
   ☐ White or Caucasian
   ☐ Prefer not to answer
   ☐ Other
   ☐ Not reported

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
☐ LIVE**STRONG**
☐ Media (TV, web, radio, print, etc.)
☐ Other (please specify): _____

6. What is your highest level of education?

☐Less than high school
☐High school diploma or equivalency (GED)
☐Associate degree (junior college)
☐Bachelor's degree
☐Master's degree
☐Doctorate
☐Professional (MD, JD, DDS, etc.)
☐Other

HEALTH INFORMATION

7. 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): _____

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

HEALTH INFORMATION CONTINUED…

8. 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		

9. Cancer diagnosis date (MM/YYYY): ____/____.

10. Surgery? ☐ Yes ☐ No 10.a. If yes, date of most recent surgery (MM/YYYY): ____/____.

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

12. Radiation? ☐ Yes ☐ No 12.a. If yes, date of last treatment (MM/YYYY): ____/____.

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

If yes, specify location (50 character limit):

14. 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):

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

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

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

If YES:

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

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

16.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.

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

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

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

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

PHYSICAL ACTIVITY INFORMATION

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

If YES:

20.a Please describe the FREQUENCY of your exercise:

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

20.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):

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

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

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

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

23. Are you working? ☐ Yes ☐ No

If YES:	If NO:
23.a What is your level of activity at work? ☐ Sedentary ☐ Light ☐ Moderate ☐ Vigorous	**23.b Since when** (MM/YYYY)**?** _____/_____.

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

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

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