



LIVESTRONG® AT THE YMCA PROGRAM ENROLLMENT FORM

PARTICIPANT DETAILS

*required information

* **Registration Date:** ____ / ____ / ____

* First Name:		Nickname/preferred:	* Last Name:	
* Date of Birth: ____ / ____ / ____ <i>MM DD YYYY</i>	* Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Address Street 1: Street 2: City: * State: * ZIP Code:		
Home Phone: () -	* Mobile Phone: () -	Preferred Contact Method (select one): <input type="checkbox"/> Email <input type="checkbox"/> Mobile - Call <input type="checkbox"/> Home Phone <input type="checkbox"/> Mobile - Text		
Email:				

How did you hear about the program? <input type="checkbox"/> Current/Former Program Participant <input type="checkbox"/> Doctor/Other Health Care Professional <input type="checkbox"/> Employer <input type="checkbox"/> Family/Friend/Word of Mouth <input type="checkbox"/> Health Insurance Company <input type="checkbox"/> Media/Marketing <input type="checkbox"/> Screening Event/Health Fair <input type="checkbox"/> Y Staff Member/Volunteer <input type="checkbox"/> Other	* What is your highest level of education? <input type="checkbox"/> Less than high school <input type="checkbox"/> High school diploma or GED <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctorate <input type="checkbox"/> Professional degree (MD, JD, DDS, etc.) <input type="checkbox"/> Other	* What is your race? (Check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> A race not listed here <input type="checkbox"/> Prefer not to answer
* Are you of Hispanic, Latino(a), or Spanish Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer	Are you a member of the Y? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer Name: _____

YMCA Staff Use ONLY:

Participant Status: <input type="checkbox"/> Enrolled <input type="checkbox"/> Wait list	Class/Cohort Name:	Class Location:
Instructor: 1. 2.	Below forms are signed and on file: <input type="checkbox"/> Medical Clearance Form <input type="checkbox"/> Consent and Release from Liability <input type="checkbox"/> Authorization for Use and Disclosure of Health Information <input type="checkbox"/> Authorization for Release of Information to Health Care Provider	

HEALTH INFORMATION

Where were you treated?

Physician name:

Have you ever had any of the following health conditions?

- | | |
|---|------------------------------|
| Pulmonary (lung) problems | <input type="checkbox"/> Yes |
| Heart problems or surgery | <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> Yes |
| Altered heart rate | <input type="checkbox"/> Yes |
| Dizziness or fainting (unrelated to cancer treatment) | <input type="checkbox"/> Yes |
| Chest, neck or arm pain | <input type="checkbox"/> Yes |
| Pain or cramping in legs while walking | <input type="checkbox"/> Yes |
| Short-term weakness on one side of the body | <input type="checkbox"/> Yes |
| Elevated blood pressure | <input type="checkbox"/> Yes |
| Low blood pressure | <input type="checkbox"/> Yes |
| High cholesterol | <input type="checkbox"/> Yes |
| Smoker or previous smoker | <input type="checkbox"/> Yes |
| Arthritis | <input type="checkbox"/> Yes |
| Other (please specify): | <input type="checkbox"/> Yes |

If you answered 'YES' to any of the above, please describe briefly:

***Type of Cancer:**

- | | | | | |
|---|--|-------------------------------------|--|--|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Endometrial | <input type="checkbox"/> Lung | <input type="checkbox"/> Prostate | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Bone | <input type="checkbox"/> Esophageal | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Rectal | <input type="checkbox"/> Uterine |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Head and Neck | <input type="checkbox"/> Myeloma | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Kidney (Renal Cell) | <input type="checkbox"/> Oral | <input type="checkbox"/> Skin (Non Melanoma) | |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Ovarian | <input type="checkbox"/> Stomach (Gastric) | |
| <input type="checkbox"/> Colon and Rectal | <input type="checkbox"/> Liver | <input type="checkbox"/> Pancreatic | <input type="checkbox"/> Testicular | |

Cancer Diagnosis Date (MM/YYYY):

- | | | | |
|----------------------|------------------------------|-----------------------------|--|
| Surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, date of most recent surgery (MM/YYYY): |
| Chemotherapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, date of last treatment (MM/YYYY): |
| Radiation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, date of last treatment (MM/YYYY): |

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

If yes, specify location:

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

If yes, specify location:

Has the cancer spread to any bones? Yes No

If yes, please describe where:

Have you had any lymph nodes removed? Yes No

If YES:

Where have you had lymph node involvement?

- | | |
|---|--|
| <input type="checkbox"/> Head and Neck | <input type="checkbox"/> Right Upper Extremity |
| <input type="checkbox"/> Left Upper Extremity | <input type="checkbox"/> Right Lower Extremity |
| <input type="checkbox"/> Left Lower Extremity | |

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.

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

If yes, please explain:

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

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

PHYSICAL ACTIVITY INFORMATION

Do you participate in exercise regularly? Yes No

If YES:

Please describe the FREQUENCY of your exercise:

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

Please describe the INTENSITY of your exercise:

- Light
- Moderate
- Vigorous

Please list the TYPES of exercise you participate in regularly:

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

If yes, please explain:

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

If yes, please explain:

Are you working?

If YES:

What is your level of activity at work:

- Sedentary
- Light
- Moderate
- Vigorous

If NO:

Since when: _____ (insert date)

Describe your past experience with resistance training and aerobic training:

What expectations do you have from this program?

Do you have any concerns about starting this exercise program?