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:	19.b Please describe the INTENSITY of your exercise:
☐ Daily ☐ 2-6 times a week ☐ Once a week ☐ Less than once per week ☐ Monthly	☐ 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):

LIVESTRONG® AT THE YMCA PROMIS-29 PROFILE

VERSION 1.0

Participant name:	Date (DD/MM/YY): / /	Timepoint: ☐ Baseline ☐ Post

Please respond to each question or statement by marking one box per row.

PHYSICAL FUNCTION Are you able to...		Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	With much difficulty	Unable to do
1	Do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐	☐
2	Go up and down stairs at a normal pace?	☐	☐	☐	☐	☐	☐
3	Go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐	☐
4	Run errands and shop?	☐	☐	☐	☐	☐	☐

ANXIETY In the past 7 days...		Never	Rarely	Sometimes	Often	Always
5	I felt fearful	☐	☐	☐	☐	☐
6	I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
7	My worries overwhelmed me	☐	☐	☐	☐	☐
8	I felt uneasy	☐	☐	☐	☐	☐

DEPRESSION In the past 7 days...		Never	Rarely	Sometimes	Often	Always
9	I felt worthless	☐	☐	☐	☐	☐
10	I felt helpless	☐	☐	☐	☐	☐
11	I felt depressed	☐	☐	☐	☐	☐
12	I felt hopeless	☐	☐	☐	☐	☐

FATIGUE In the past 7 days...		Not at all	A little bit	Somewhat	Quite a bit	Very much
13	I feel fatigued	☐	☐	☐	☐	☐
14	I have trouble starting things because I am tired	☐	☐	☐	☐	☐
15	How run-down do you feel on average?	☐	☐	☐	☐	☐
16	How fatigued did you feel on average?	☐	☐	☐	☐	☐
SLEEP DISTURBANCE In the past 7 days...		Very poor	Poor	Fair	Good	Very good
17	My sleep quality was	☐	☐	☐	☐	☐
In the past 7 days...		Not at all	A little bit	Somewhat	Quite a bit	Very much
18	My sleep was refreshing	☐	☐	☐	☐	☐
19	I had a problem with my sleep	☐	☐	☐	☐	☐
20	I had difficulty falling asleep	☐	☐	☐	☐	☐

SATISFACTION WITH SOCIAL ROLE In the past 7 days...		Not at all	A little bit	Somewhat	Quite a bit	Very much
21	I am satisfied with how much work I can do (include work at home)	☐	☐	☐	☐	☐
22	I am satisfied with my ability to work (include work at home)	☐	☐	☐	☐	☐
23	I am satisfied with my ability to do regular personal and household responsibilities	☐	☐	☐	☐	☐
24	I am satisfied with my ability to perform my daily routines	☐	☐	☐	☐	☐

PAIN INTERFERENCE In the past 7 days...		Not at all	A little bit	Somewhat	Quite a bit	Very much
25	How much did pain interfere with your day to day activities?	☐	☐	☐	☐	☐
26	How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
27	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
28	How much did pain interfere with your household chores?	☐	☐	☐	☐	☐

PAIN INTENSITY In the past 7 days...		No pain										Worst imaginable pain
29	How would you rate your pain on average?	0	1	2	3	4	5	6	7	8	9	10

LIVE**STRONG** at the YMCA Informed Consent

First Name: _____ Last Name: _____

Today's Date: _____ Age: _____ Date of Birth: _____

Male or Female (circle one)

Informed Consent

I understand that the purpose of an exercise program is to develop and maintain cardiorespiratory fitness, muscular strength and endurance, and flexibility and balance. A specific exercise plan will be designed for me, based on my needs and interest. All exercise programs include warm-up, exercise, and cool-down. The programs include, but are not limited to aerobic exercise, strength training, and flexibility. All programs are designed to place a gradually increasing workload on the body in order to improve overall fitness. The rate of progression is regulated by the rate of my perceived effort of exercise. I understand that I am responsible for monitoring my own condition throughout the exercise program and should any symptoms occur, I would cease my participation and inform the instructor of the symptoms.

In signing this consent form, I affirm that I have read this form in its entirety and I understand the nature of the exercise program. I also affirm that my questions regarding the exercise program have been answered to my satisfaction.

In the event that medical clearance must be obtained prior to my participation in the exercise program, I agree to consult my physician and obtain written permission from my physician prior to the commencement of any exercise program.

Also, in consideration for being allowed to participate in this exercise program, I agree to assume the risk of such exercise, and further agree to hold harmless the _____, it's employees and agents, from any and all claims, suits, losses or related causes of action for damages, including, but not limited to, such claims that may result in my injury or death, accidental or otherwise, during or arising in any way from the exercise program.

*As part of your participation in the LIVE**STRONG** at the YMCA: A Cancer Survivor Exercise Program, we ask that you complete the requested paperwork, surveys, and functional assessments.* ***All responses/outcomes are kept confidential; your responses/performance will not be shared with anyone outside the*** *LIVE**STRONG** at the YMCA program. The information you provide may be combined with other respondents answers and analyzed and reported in order to help evaluate the programs effectiveness, as well as plan future programs. Thank you for your participation in the program and also for completing the surveys.*

_____ _____

Signature of participant Date

_____ _____

Contact in case of emergency Phone number

LIVE**STRONG**® AT THE YMCA

Thank you for participating in the LIVE**STRONG** at the YMCA program. At the LIVE**STRONG** Foundation, our mission is to inspire and empower people affected by cancer. With this in mind, we wanted to ensure that you are aware of additional ways we can support you and opportunities to get involved with the Foundation.

Please review the services below and check any that you are interested in discussing with a LIVE**STRONG** Foundation staff member. All services below are available for free to you and your loved ones.

- ☐ Emotional and peer support
- ☐ Clinical trials education and/or matching
- ☐ Fertility education
- ☐ Insurance, financial or work-related concerns
- ☐ Opportunities to get involved with the LIVE**STRONG** Foundation (raising awareness, advocating, etc.)

By supplying your information and signature below, you are providing the Foundation consent to contact you to further discuss your selections above.

If you have immediate needs, please contact us toll-free at 1.855.220.7777, Monday – Friday from 9am – 5pm.

PLEASE PRINT

DATE:	**GENDER:** ☐ Male ☐ Female	**CANCER TYPE:**
FIRST NAME:	**LAST NAME:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PHONE NUMBER:	**EMAIL ADDRESS:**	
ETHNICITY: ☐ I prefer not to respond ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian/White ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Mixed-race ☐ Other	**AGE:** ☐ I prefer not to respond ☐ 0-14 ☐ 15-17 ☐ 18-25 ☐ 26-39 ☐ 40-50 ☐ 51-64 ☐ 65+	
SIGNATURE:		

By sharing your contact information and details related to your cancer experience, we can best match you to resources that can assist you. Your information is confidential and will not be shared with anyone outside of the Foundation and our partners to provide you with requested services.

Completed forms can be sent to the LIVE**STRONG** Foundation via email at ymca@livestrong.org, fax (512)236-8482 or mail at 2201 East Sixth Street Austin, TX 78702.

Medical Clearance Form

Date:_____

Client's Name:_____ Physician's Name:_____

Client's Phone:_____ Physician's Phone:_____

Client's DOB:_____ Physician's Fax:_____

Dear Dr. _____,

Your client _____ has requested to participate in LIVE**STRONG**® at the YMCA: A Cancer Survivor Exercise Program at the _____YMCA. AT the start of this program, your client will participate in a fitness assessment, including the 6 minute walk test, one repetition max test for upper and lower body, and balance and flexibility test. Following the fitness assessment, your client will partake in cardiorespiratory fitness, muscular strength and endurance, and flexibility and balance activities. A specific, individualized exercise program will be created for the participant based on his/her needs and interests, and any recommendations you might have. The LIVE**STRONG** at the YMCA program is designed to start at an easy level and become progressively difficult over a 12-week period. All fitness assessment and exercsie activities will be administered by qualified personnel trained in conducting exercise tests and exercise programs for cancer survivors.

Based on the LIVE**STRONG** at the YMCA Intake form, your client has indicated a diagnosed medical condition, coronary risk factor, and/or health condition that requires a physician's clearance prior to participation in the LIVE**STRONG** at the YMCA program.

By completing the form below, you are not assuming any responsibility for our administration of the fitness assessment or exercise program. IF you know of any medical or other reasons why participation in the LIVE**STRONG** at the YMCA program would be unwise for your client, please indicate so on this form.

If you have any questions regarding LIVE**STRONG** at the YMCA, please call:
Program Coordinator: _____ Phone: _____ Fax: _____

Provider's Report:
My client, listed above, is:

____ Not cleared to exercise at this time
____ Cleared to exercise with no restrictions
____ Cleared to exercise with the following restrictions and/or recommendations:

_____

Physician's name: _____
Physician's signature: _____ Date: _____

the YMCA FOR YOUTH DEVELOPMENT® FOR HEALTHY LIVING FOR SOCIAL RESPONSIBILITY

YMCA OF METROPOLITAN DALLAS

Member Information Form

Member Number	
Driver's License #	Staff Initials

Adult Name	First Name	Middle Name	Last Name	Nickname

PRIMARY MEMBER INFORMATION

STREET ADDRESS	
APT OR PO BOX NUMBER	ZIP CODE
CITY	STATE
GENDER	BIRTHDATE / /
HOME PHONE NUMBER	CELL PHONE NUMBER
EMAIL ADDRESS	

Family Members (First, MI)

ADULT	GENDER	BIRTHDATE / /	RELATIONSHIP
ADULT		/ /	
CHILD		/ /	
CHILD		/ /	
CHILD		/ /	
CHILD		/ /	

EMERGENCY INFORMATION	EMERGENCY CONTACT NAME	RELATIONSHIP	EMERGENCY PHONE NUMBER

EMPLOYMENT INFORMATION	BUSINESS NAME

OPTIONAL – PROVIDING THE FOLLOWING INFORMATION ASSISTS THE YMCA IN MEETING UNITED WAY REPORTING REQUIREMENTS

ANNUAL HOUSEHOLD INCOME

☐ UNDER $14,999 ☐ $15,000-$24,999 ☐ $25,000-$34,999 ☐ $35,000-$49,999 ☐ $50,000-$64,999 ☐ $65,000-$74,999 ☐ $75,000-$99,999 ☐ $100,000-$149,999 ☐ $150,000 & OVER

ETHNIC ORIGIN

☐ CAUCASIAN ☐ NATIVE AMERICAN ☐ HISPANIC ☐ AFRICAN AMERICAN ☐ ASIAN ☐ PACIFIC ISLANDER ☐ OTHER_____

MEMBERSHIP TYPES

☐ TEEN ☐ YOUNG ADULT ☐ ADULT ☐ FAMILY ☐ SENIOR ☐ SENIOR FAMILY ☐ OTHER_____

CREDIT CARD ACCOUNT			CHECKING ACCOUNT	
NAME ON CARD			NAME ON ACCOUNT	
ACCOUNT NUMBER (LAST 4 DIGITS ONLY)	☐ ☐ ☐ ☐ ☐ AMEX ☐ DISCOVER ☐ M/C ☐ VISA		ACCOUNT NUMBER (LAST 4 DIGITS ONLY)	☐ ☐ ☐ ☐ ☐ CHECKING ☐ SAVING
FULL NAME OF BANK	CARD EXPIRATION DATE	CW2#	ROUTING/TRANSIT NUMBER	

CREDIT CARD/BANK DRAFT AGREEMENT

INITIAL HERE

1. Credit Card/Bank Draft is a continuous membership plan. Your membership will remain active until you submit a written 30-day termination notice.
2. The YMCA may, at its discretion, adjust the monthly rate it charges for your membership. You will receive at least 30 days notice prior to any change.
3. Should any preauthorized credit or bank draft not be honored by the issuer when received by them, the YMCA will automatically resubmit that draft for payment within ninety (90) days and add to it a $25 service charge. The YMCA service charge is in addition to any service fee your bank will charge. After two (2) unpaid drafts/months, the YMCA will immediately terminate your membership until all payments are up to date.

OTHER MEMBERSHIP POLICIES

INITIAL HERE

1. With approval from the Executive Director, your membership can be placed on hold for (3) months per 12-month period at no charge for reasons of medical injury or illness or extended travel. You must give thirty (30) days written notice prior to the month(s) you wish to have your membership put on hold.
2. Membership Cards are not transferable to anyone else and remain the property of the YMCA and must be surrendered upon termination of your membership.
3. There may be a fee assessed for replacement membership cards.
4. A Joiner Fee will be reassessed to memberships that have lapsed for more than sixty (60) days

THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THIS ACKNOWLEDGMENT OF RISK AND WAIVER OF LIABILITY, AND FURTHER AGREES THAT NO REPRESENTATIONS OR STATEMENTS OTHER THAN THOSE SET FORTH HEREIN HAVE BEEN MADE.

BY MY SIGNATURE BELOW I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTOOD AND AGREE TO THE FOREGOING BEHAVIOR POLICY STATEMENT, CHILD ABUSE INFORMATION, PARENTAL PERMISSIONS, ACKNOWLEDGMENTS, HIGH RISK ASSUMPTION OF RISKS, PHOTO/VIDEO RELEASE AND LIABILITY RELEASE, UNDERSTAND THE CONTENTS OF EACH SECTION AND AM AWARE THAT I AM RELEASING CERTAIN LEGAL RIGHTS THAT I MIGHT OTHERWISE HAVE.

I have given authority to the bank or credit card issuer named below to honor preauthorized debits drawn by the YMCA on my account for membership payments as indicated. It is understood that the draft on my account shall constitute valid notice of such payment due on my membership. When the bank or credit card issuer honors the payment, my account statement shall constitute receipt for the payment.

Members must maintain active membership throughout the duration of an enrolled program to continue to participate in the program at the member rate. If your membership lapses or is terminated prior to or during the enrolled program, you will be charged the difference between the member rate and the non-member rate. This amount will be due at termination of membership.

SIGNATURE _____ DATE _____

FIRST DRAFT DATE	STAFF SOLD