PARTICIPANT INTEREST FORM

Contact Information:

Name:_____

Address:_____

City/State/Zip:_____

E-mail:_____

Cell Phone:_____ Home Phone: _____

Program Information:
Would you prefer (circle one): **Days** | **Evenings**

Session date (circle one): **Winter** | **Summer (days only)** | **Fall**

Sessions may be held at these locations. Please circle your preference:

Northeast Family YMCA	**SwedishAmerican Riverfront YMCA**	**Puri Family YMCA**
Days or Evenings	Days Only	Days Only
8451 Orth Rd. Loves Park, IL 61111	200 Y Blvd. Rockford, IL 61107	1475 S Perryville Rd. Rockford, IL 61108

Please return forms to:
One of our YMCA branches listed above
Attn: Mya Williams, Evidence-Based Health Interventions Coordinator
myawilliams@rockriverymca.org
Phone: 815-885-6822 | Fax: 815-885-4768

_____

For office use:
Date of Inquiry_____
Notes:_____
_____
_____

LIVE**STRONG** at the YMCA Instructor Signature_____

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:		
Were you a Y member prior to joining the LIVE**STRONG** at the YMCA program? Circle one: YES / NO		

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]

   ☐ 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
☐ 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):

Association: Branch:

LIVESTRONG® AT THE YMCA PROMIS-29 PROFILE

VERSION 1.0

Participant name:	Date (MM/DD/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	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

LIVESTRONG® AT THE YMCA

Medical Clearance Form

PATIENT NAME:_____

DATE:_____ **PHONE:**_____

Your patient would like to participate in the YMCA of Rock River Valley LIVESTRONG at the YMCA Cancer Survivor Exercise Program. The program is designed for adult patients who have become de-conditioned or chronically fatigued from their treatment and/or disease. The program includes multiple components including: cardio respiratory, muscle strengthening, flexibility, and nutritional education. A specific, individualized exercise program will be created for the participant, based on needs, interests, and any recommendation you may provide.

The program is designed to begin with easy, simple exercises and progress to an increased but appropriate workload over the 12-week session. Following these principles will over time, improve overall fitness and muscular strength.

Our LIVESTRONG at the YMCA program will be administered in a small group setting of 10-12 participants by certified fitness instructors with direct certification in cancer survivorship needs and assessment.

PLEASE RETURN BY FAX TO: (815)885-4768

Attn: Kathleen Hedrick
LIVESTRONG at the YMCA Project Manager
Phone: 815-885-6822
Email: khedrick@rockriverymca.org

REPORT OF PHYSICIAN (Please check one):

_____ I know of no reason why the applicant may not participate.

_____ I believe the applicant can participate, but I urge caution because:

_____

_____ The applicant should not engage in the following activities:

_____

_____ I recommend this applicant **NOT** participant at this time.

PHYSICIANS NAME (PRINT):_____

PHYSICIANS SIGNATURE:_____ DATE: _____

PHONE NUMBER: (_____) _____

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Participant Name:		
Date of Birth (MM/DD/YYYY):	Phone Number:	
Mailing Address:		
City:	State:	Zip Code:
Email Address:		
Emergency Contact Name:		
Relationship to Participant:	Emergency Contact Phone Number:	

LIVE**STRONG® at the YMCA CONSENT AND RELEASE FROM LIABILITY**

I hereby consent to voluntarily participate in LIVE**STRONG** at the YMCA. I understand the goal of the program is to help adult cancer survivors develop and maintain cardiorespiratory fitness, muscular strength and endurance, flexibility and balance. The program is designed to gradually increase workload on the body 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 exercises and should any symptoms occur, I would cease my participation and inform the instructor and my physician of the symptoms.

I agree to consult my physician and obtain written permission from my physician prior to the commencement of the LIVE**STRONG** at the YMCA program. I understand the YMCA does not practice medicine and the program is not a substitute for the care I receive from my physician or other qualified health care providers. I understand the LIVE**STRONG** instructor is not a qualified health care professional, does not practice medicine, and support provided by the instructor is not a substitute for the care I receive from my qualified health care providers.

In consideration for being allowed to participate in this program, I agree to assume the risk of such exercise, and further agree to hold harmless the YMCA, its 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 my participation in the LIVE**STRONG** at the YMCA Program.

By signing below, I affirm that I have read the above in its entirety, and I understand the nature of the LIVE**STRONG** at the YMCA Program. I also affirm that my questions regarding the program have been answered to my satisfaction.

Signature of participant: _____ Date: _____

AUTHORIZATION FOR
RELEASE OF INFORMATION TO HEALTH CARE PROVIDER

I voluntarily authorize YMCA of Rock River Valley to release or disclose my protected health information related to my participation in the LIVE**STRONG** at the YMCA Program to my primary care physician and/or other individuals referenced below. I understand that I have a right to receive a copy of this authorization, and the information disclosed pursuant to this authorization may be redisclosed by the person(s) listed below. I understand that I am not required to sign this form to participate in the program and that I may revoke this authorization at any time by submitting my revocation in writing to the YMCA.

Primary Care Physician Practice:		
Physician Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Email:		

Other individual(s)

Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Email:		

If this authorization has not been revoked, it will terminate five (5) years after your completion of your last program, unless a shorter period is specified under state law.

Signature of participant: _____ Date: _____