PARTICIPANT INTAKE FORM

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. How did you learn about the Strength for Survivors Program?
    - Y Staff member of volunteer
    - A friend or family word of mouth
    - A doctor or other health care professional
    - A poster or flyer at the Y
    - A poster or flyer at a cancer or medical center
    - The Y's Website
    - Media
    - Other (Please specify):_____
4. Have you ever had any of the following health problems?
    - Pulmonary (lung) problems
    - Heart problems or surgery
    - Diabetes
    - Altered heart rate
    - Dizziness or fainting (unrelated to cancer treatment)
    - Chest, neck or arm pain
    - Pain or cramping in legs while walking
    - Short-term weakness on one side of the body
    - Elevated blood pressure
    - Low blood pressure
    - High cholesterol
    - Smoker or previous smoker
    - Arthritis
    - Other (please specify):_____

4.a If you answered "YES" to any of the above, please describe briefly:

5. Type of Cancer:
   - ○ Bladder
   - ○ Bone
   - ○ Brain
   - ○ Breast
   - ○ Cervical
   - ○ Colon and Rectal
   - ○ Endometrial
   - ○ Head and Neck
   - ○ Kidney
   - ○ Leukemia
   - ○ Liver
   - ○ Lung
   - ○ Lymphoma
   - ○ Myeloma
   - ○ Oral
   - ○ Ovarian
   - ○ Pancreatic
   - ○ Prostate
   - ○ Rectal
   - ○ Melanoma
   - ○ Skin (Non Melanoma)
   - ○ Stomach (Gastric)
   - ○ Testicular
   - ○ Thyroid
   - ○ Uterine
   - ○ Other:_____

6. Cancer diagnosis date (MM/YY): _____/_____

7. Surgery? Yes No 7.a If yes, date of most recent surgery: _____

8. Chemotherapy? Yes No 8.a. If yes, date of last treatment:_____

9. Radiation? Yes No 9.a. If yes, date of last treatment:_____

10. Hormone Therapy Yes No 10.a If yes, date of last treatment:_____

10. b If yes, what symptoms are you having_____

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

If yes, specify location:

12. Has the cancer spread to any bones? Yes No

If yes, please describe where:

13. Have you had any lymph nodes removed? Yes No

If YES:

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

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

12. 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.

14. Are there any other major illnesses, injury or issues (physical or psychological) we should be aware of?

If yes, please explain:

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

PHYSICAL ACTIVITY INFORMATION

16. Do you participate in exercise regularly? Yes No

If YES:

15. a Please describe the FREQUENCY of your exercise:	15. 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
15.c. Please list the TYPES of exercise you participate in regularly:	

17. Do you have any physical limitations that restrict your daily living activities or ability to exercise?

18. Are there any other limitations since your cancer diagnosis?

19. Are you working? Yes No

If YES, If NO,

18.a What is your level of activity at work?	18.b. Since when (MM/YY)?_____
Sedentary Light Moderate Vigorous	

20. Describe your past experience with resistance training and aerobic training:

21. What expectations do you have from this program:

22. Do you have any concerns about starting this exercise program: