LIVESTRONG® AT THE YMCA PROGRAM ENROLLMENT FORM

PARTICIPANT DETAILS

*required information

*** Registration Date:** _____ /_____ /_____

*** First Name:**	**Nickname/preferred:**	*** Last Name:**
*** Date of Birth:** _____ /_____ /_____ MM DD YYYY	*** Sex:** ☐ Male ☐ Female	**Address** Street 1: Street 2: City: *** State:** *** ZIP Code:**
Home Phone: ( ) -	*** Mobile Phone:** ( ) -	
Email:		**Preferred Contact Method** *(select one)*: ☐ Email ☐ Mobile - Call ☐ Home Phone ☐ Mobile - Text

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

YMCA Staff Use ONLY:

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

Updated 10/2019

HEALTH INFORMATION

Where were you treated?
Physician name:

Have you ever had any of the following health conditions?	
Pulmonary (lung) problems	☐ Yes
Heart problems or surgery	☐ Yes
Diabetes	☐ Yes
Altered heart rate	☐ Yes
Dizziness or fainting (unrelated to cancer treatment)	☐ Yes
Chest, neck or arm pain	☐ Yes
Pain or cramping in legs while walking	☐ Yes
Short-term weakness on one side of the body	☐ Yes
Elevated blood pressure	☐ Yes
Low blood pressure	☐ Yes
High cholesterol	☐ Yes
Smoker or previous smoker	☐ Yes
Arthritis	☐ Yes
Other (please specify):	☐ Yes
If you answered 'YES' to any of the above, please describe briefly:	

* **Type of Cancer:**				
☐ Bladder	☐ Endometrial	☐ Lung	☐ Prostate	☐ Thyroid
☐ Bone	☐ Esophageal	☐ Lymphoma	☐ Rectal	☐ Uterine
☐ Brain	☐ Head and Neck	☐ Myeloma	☐ Melanoma	☐ Other (please specify):
☐ Breast	☐ Kidney (Renal Cell)	☐ Oral	☐ Skin (Non Melanoma)	
☐ Cervical	☐ Leukemia	☐ Ovarian	☐ Stomach (Gastric)	
☐ Colon and Rectal	☐ Liver	☐ Pancreatic	☐ Testicular	

Cancer Diagnosis Date (MM/YYYY):			
Surgery?	☐ Yes	☐ No	If yes, date of most recent surgery (MM/YYYY):
Chemotherapy?	☐ Yes	☐ No	If yes, date of last treatment (MM/YYYY):
Radiation?	☐ Yes	☐ No	If yes, date of last treatment (MM/YYYY):

Do you have an implemented 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?

☐ Head and Neck ☐ Right Upper Extremity

☐ Left Upper Extremity ☐ Right Lower Extremity

☐ 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?