YMCA of Greater Syracuse
340 Montgomery St.
Syracuse, NY 13202
(315) 474-6851 ext 339

LIVESTRONG® AT THE YMCA INTAKE FORM

PARTICIPANT INFORMATION

Name:							Date (DD/MM/YY):			
Address:			City:				ZIP CODE:			
Preferred contact method: Phone		Mail		Email		Phone #:				
Email:					Referred by:					
Date of Birth	Male		Female		Y Member?	Yes		No		
Where were you treated?				Physician name:						
Emergency Contact:							Phone:			

Upcoming 2018 Dates (please check next to program interest)

EAST YMCA (Fayetteville) Tuesdays and Thursdays AM: 10:30-12:00 PM: 6:00-7:30		**NORTH YMCA (Liverpool)** Tuesdays and Thursdays 1:00-2:30 pm		**SOUTHWEST YMCA (OCC Campus)** Tuesdays and Thursdays 6:00-7:30 pm		**NORTHWEST YMCA (Baldwinsville)** Mondays and Wednesdays 6:00-7:30 pm	
Session 1 (AM) Jan 9-March 29		Session 1 Feb 20-May 10		Session 1 Feb 6 – April 26		Session 1 Jan 29 - April 18	
Session 2 (PM) Jan 23-April 12		Session 2 June 26-Sept 13		Session 2 June 5- Aug 23		Session 2 May 14 - Aug 8	
Session 3 (AM) April 10-June 28		Session 3 Oct 15-Jan 9,2019		Session 3 Oct 2 – Jan 3 2019		Session 3 Sept 17 - Dec 5	
Session 4 (PM) April 24-July 12						**FULTON YMCA** Mondays and Wednesdays 11:00 am-12:30 pm	
Session 5 (AM) Sept 4-Nov 29						Session 1 March 5- May 23	
Session 6 (PM) Sept 25-Dec 13						Session 2 Sept 24- Dec 12	

1. 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

2. 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

HEALTH INFORMATION

3. 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):

4. Type of Cancer:

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

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

6. Surgery? ☐ Yes ☐ No 9. a. If yes, date of most recent surgery (MM/YY): _____/

7. Chemotherapy? ☐ Yes ☐ No 10. a. If yes, date of last treatment (MM/YY): _____/

8. Radiation? ☐ Yes ☐ No 11. a. If yes, date of last treatment (MM/YY): _____/

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

If yes, specify location (50 character limit):

10. 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):

11. Has the cancer spread to any bones? ☐ Yes ☐ No

If yes, please describe where (50 character limit):

12. Have you had any lymph nodes removed? ☐ Yes ☐ No

If YES:

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

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

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

13.a. If yes, please explain (255 character limit):

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

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:

16.a Please describe the FREQUENCY of your exercise:
☐ Daily
☐ 2-6 times a week
☐ Once a week
☐ Less than once per week
☐ Monthly

16.b Please describe the INTENSITY of your exercise:
☐ Light
☐ Moderate
☐ Vigorous

16.c Please list the TYPES of exercise you participate in regularly (255 character limit):

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

17.a If yes, please explain (255 character limit):

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

18 a If yes, please explain (255 character limit):

19. Are you working? ☐ Yes ☐ No

If YES:	If NO:
19.a What is your level of activity at work? ☐ Sedentary ☐ Light ☐ Moderate ☐ Vigorous	19.b Since when (MM/YY)? ____/____

20. Describe your past experience with resistance training and aerobic training (255 character limit):

21. What expectations do you have from this program (255 character limit):

22. Do you have any concerns about starting this exercise program (255 character limit):