LIVE**STRONG** at the YMCA Informed Consent

First Name: _____ Last Name: _____

Today's Date: _____Age: _____ Date of Birth: _____ Male or Female

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 CCA YMCA, 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

Medical Clearance Form

Date: **Physicians' Name:**

Client's Name: **Physician's Phone:**

Client's Phone: **Physician's Fax:**

Client's DOB:

Dear Doctor _____,

Your patient _____ 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 patient 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 the needs, interests and any recommendations you might have. The LIVE**STRONG** program is designed to start easy and become progressively more difficult over a 12 week period. All fitness assessments and exercise activities will be administered by qualified personnel trained in conducting exercise test and exercise programs.

Based on the LIVE**STRONG** at the YMCA intake form, your patient has indicated a diagnosed medical condition, coronary risk factor, and/or health condition that require 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 patient, please indicate so on this form.

If you have any questions regarding the LIVE**STRONG** at the YMCA program, please call the program coordinator.

Program Coordinator: Pamela Heaton Phone (856-691-0030 x. 118)
Return Fax (856-696-0121)

Physicians Report
My patient, 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

_____
_____

Physicians Name: _____

Physicians Signature: _____ Date: _____

Association: Branch:

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
☐ 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):

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
☐ Left Upper Extremity
☐ Left Lower Extremity
☐ Right Upper Extremity
☐ Right 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:

☐ Daily
☐ 2-6 times a week
☐ Once a week
☐ Less than once per week
☐ Monthly

19.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):

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):

Association: Branch:

LIVESTRONG® AT THE YMCA FUNCTIONAL ASSESSMENT

PARTICIPANT INFORMATION

Name: DOB (DD/MM/YYYY): / /	Gender: ☐ Male ☐ Female
Assessment date (DD/MM/YYYY): / /	Timepoint: ☐ Baseline ☐ Post

AEROBIC FUNCTION

6 Minute Walk Test											
Beginning HR:		Ending HR:		Number of laps (full & partial):				Total Distance (meters):			
Beginning RPE:	0	1	2	3	4	5	6	7	8	9	10
End RPE:	0	1	2	3	4	5	6	7	8	9	10
Comments:											

STRENGTH TESTING	
Leg Press (1 rep max)	Max Weight (lbs):
Chest Press (1 rep max)	Max Weight (lbs):
Comments:	

FLEXIBILITY AND BALANCE	
Back Scratch	Right Up:
	Left Up:
Arm Reach	Beginning:
	Reach:
Single Leg Stance -Shoes off -Up to 60 seconds	Right leg:
	Left leg:
Comments:	

Association: Branch:

LIVESTRONG® AT THE YMCA FUNCTIONAL ASSESSMENT

PARTICIPANT INFORMATION

Name: DOB (DD/MM/YYYY): / /	Gender: ☐ Male ☐ Female
Assessment date (DD/MM/YYYY): / /	Timepoint: ☐ Baseline ☐ Post

AEROBIC FUNCTION

6 Minute Walk Test											
Beginning HR:		Ending HR:		Number of laps (full & partial):				Total Distance (meters):			
Beginning RPE:	0	1	2	3	4	5	6	7	8	9	10
End RPE:	0	1	2	3	4	5	6	7	8	9	10
Comments:											

STRENGTH TESTING	
Leg Press (1 rep max)	Max Weight (lbs):
Chest Press (1 rep max)	Max Weight (lbs):
Comments:	

FLEXIBILITY AND BALANCE	
Back Scratch	Right Up:
	Left Up:
Arm Reach	Beginning:
	Reach:
Single Leg Stance -Shoes off -Up to 60 seconds	Right leg:
	Left leg:
Comments:	

LIVESTRONG® AT THE YMCA

Thank you for participating in the LIVE**STRONG** at the YMCA program. At LIVE**STRONG**, our mission is to improve the lives of people affected by cancer, now. 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 regardless of where you are in your cancer journey.

- ☐ Emotional and peer support (fear of recurrence, body image concerns, survivor's guilt, ongoing stress etc.)
- ☐ Information or resources on adjusting to life post-treatment or healthy living after cancer
- ☐ Support with medical decision-making
- ☐ 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 LIVE**STRONG** 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 – Thursday from 8:30am – 5pm EST, and Friday from 8:30am – 4pm EST.

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 LIVE**STRONG** 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.

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