



Hope is Power Intake Form

Name: _____ Age _____ DOB: _____ Todays Date: _____

Address _____

City, State, Zip _____

Phone Number (preferred): _____ Email: _____

Emergency Contact Name and Phone Number: _____

Where were you treated: _____ Physician: _____

Physician Phone Number: _____ Are you a YMCA member? _____

How did you learn about the Hope is Power cancer survivorship program(s)?

Have you ever had any of these health problems?

Pulmonary (lung) problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart problems or surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Altered heart rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness or fainting (unrelated to cancer x-ment)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest, neck or arm pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain or cramping in legs while walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Short-term weakness on one side of the body	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Elevated blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoker or previous smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If the answer is yes to any of the above, please describe briefly:

Cancer diagnosis and treatment: please respond specifically to all that apply.

Type of cancer and date _____

Type of surgery and date _____

Chemotherapy and date of last treatment _____

Radiation and date of last treatment _____

Do you now have an implanted port or Central Venous Access Catheter?

Yes (location _____) No

Are you experiencing any peripheral neuropathy (such as tingling or loss of sensation in your fingers and/or toes)? Yes No

If yes, please describe where _____

Has the cancer spread to any bones? Yes No

If yes, please describe where _____

If you have had Lymph Nodes removed:

Have you had any Lymph Nodes removed? Yes No

If yes, please answer the following questions:

- How many? _____

Please check which box applies to you:

- Head and Neck
- Upper Extremity
- Lower Extremity

- Where from? _____
- What side of the body? _____
- Have you been diagnosed w/Lymphedema? Yes No
- Are you currently experiencing any stiffness or loss of Range of Motion in the area that the Lymph Nodes have been removed? Yes No
- Are you currently experiencing any pain or discomfort in the area that the Lymph Nodes have been removed? Yes No

Have you received radiation? Yes No

If so, where? _____

Has your doctor ever prescribed a compression garment or stocking? Yes No

Are you presently being treated by a doctor or other medical person for a physical or psychological problem other than routine check-ups? Yes No

If yes, please explain:

Is there anything you do differently now than you did before your cancer diagnosis? (ex. your spouse carries in the groceries, etc.)? Yes No

If yes, please explain:

Other major illnesses (include surgeries/accidents/chronic pain):

List current medications (including vitamins and over-the-counter):

Describe your health at the present time Excellent Good Fair Poor

Have you seen a dietician since your cancer diagnosis? Yes No

List types of exercise you participate in regularly and describe the frequency of your practice

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

Yes No

If yes, please explain _____

10. Are you working? Yes No

What is your level of activity at work? Completely sedentary Moderately active
 Very active/physical

Describe your past experience with resistance training and aerobic training:

Do you have any concerns about starting this exercise program?

What expectations do you have from this first session?



HOPE IS POWER

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 Hope is Power: A Cancer Survivor Exercise Program at the Valley Shore 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 Hope is Power 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 Hope is Power 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 Hope is Power 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 Hope is Power program would be unwise for your patient, please indicate so on this form.

If you have any questions regarding the Hope is Power program, please call the program coordinator.

Program Coordinator: Tony Sharillo Phone (860)-399-9622 x107
 Return Fax (860)-399-8349

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: _____