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	□ Yes	□ No
Heart problems or surgery	□ Yes	□ No
Diabetes	□ Yes	□ No
Altered heart rate	□ Yes	□ No
Dizziness or fainting (unrelated to cancer x-ment)	□ 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

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: Ellen Nichele

Phone (860)-399-9622 x121
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: _____