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?

_____
_____
_____