FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Overview:

Partners in Recovery

- ☐ 3 months free membership for cancer patient/ survivor and their caregiver.
- ☐ One-on-one wellness support with a personal trainer.

Partners in Recovery is a free 12-week cancer wellness program designed to help survivors improve strength and quality of life.

Preliminary Questions:

Today's date:

First Name	MI	Last Name

Age	Date of Birth	Male ☐	Female ☐

Phone #:

How did you hear about the Cancer Survivor Wellness Support Program?

Informed Consent

The purpose of this program is to help individuals help themselves become healthier and more physically fit. Cardiovascular training, resistance training, and flexibility training may be incorporated into any exercise program. I understand that I am responsible for monitoring my own condition while exercising, and should any unusual symptoms occur, I will cease my participation and inform the trainer or instructor of the symptoms. In signing this consent form, I affirm that I have read this form in its entirety, and that I understand the risks of exercise. I also affirm that my questions regarding my exercise program have been answered to my satisfaction. In the event that medical clearance must be obtained prior to my participation in an exercise program, I agree to consult my physician and obtain written approval from my physician prior to the commencement of any exercise.

Also, in consideration of being allowed to participate in any exercise program, I agree to assume the risk of such a program. I further agree to assume the risk to hold harmless the Sanford Springvale YMCA and its staff members from any and all claims, suits, losses or related causes of action for damage, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, during or arising in any way from any exercise or exercise program.

As part of your participation in the Cancer Survivor Wellness Support Program, we ask that you complete the attached surveys. **All responses will be kept confidential; your individual answers will not be shared with anyone outside of the Sanford-Springvale YMCA.** The information you provide will be combined with other respondents' answers to be analyzed and reported in order to help us evaluate the program's effectiveness, as well as plan future programs. Thank you for your participation in the program and also completing the surveys.

Signature of Participant Date

Emergency Contact Phone

Preliminary Questions:

Today's date:

Type of cancer & date of diagnosis: _____

Cancer related surgeries: _____

Cancer related treatment: _____

Major side effects: _____

_____

_____

Orthopedic Problems:

Do you have any orthopedic problems that would limit you from exercising? ☐ Yes or ☐ No

Health Conditions

Please check any of the following health conditions you are experiencing or have experienced in the recent past:

Cardiovascular

- ☐ Chest discomfort/angina
- ☐ Coronary Bypass Surgery or PICA
- ☐ Current Heart Murmer
- ☐ Extra, Skipped or Rapid Heart Beat(Arrhythmia)
- ☐ Heat Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Low Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stroke or TIAs

Musculoskeletal

- ☐ Foot Problems
- ☐ Ankle Swelling
- ☐ Knee Problems
- ☐ Back Problems
- ☐ Shoulder Problems
- ☐ Fibromyalgia
- ☐ Swollen, Sore, or Painful Joints
- ☐ Joint Replacement
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis

Pulmonary

- ☐ Allergies: _____
- ☐ Asthma
- ☐ Pulmonary Edema

Other

- ☐ Anemia
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Parkinson's Disease
- ☐ Neuropathies
- ☐ Lymphedema
- ☐ Dizziness
- ☐ Loss of Balance

Is there any more information we should know about which would be relevant to your participation in this program?

_____

_____

Physical Fitness:

Today's date:

1. How would you rate your overall level of physical fitness?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

1 2 3 4 5 6

2. How would you rate the muscle strength in your legs?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

1 2 3 4 5 6

3. How would you rate the muscle strength in your arms?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

1 2 3 4 5 6

4. How would you rate your level of endurance or stamina?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

1 2 3 4 5 6

5. How would you rate your overall energy?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

1 2 3 4 5 6

6. How would you rate your weight compared to others your age and gender?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

1 2 3 4 5 6

7. How would you rate your muscle tone?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

1 2 3 4 5 6

Vitality Plus Scale

Today's date:

This scale is about how you are *currently feeling*. For each statement circle the number from 1 to 5 that best describes you. For instance, if you usually fall asleep quickly when you want to, circle 5. Otherwise circle the number 1 thru 4 depending on the extend to which you have difficulty falling asleep.

1.	Takes a long time to fall asleep	1	2	3	4	5	Fall asleep quickly
2.	Sleep poorly	1	2	3	4	5	Sleep Well
3.	Tired or drowsy during the day	1	2	3	4	5	Feel rested
4.	Rarely hungry	1	2	3	4	5	Excellent appetite
5.	Often constipated	1	2	3	4	5	Do not get constipated
6.	Often have aches and pains	1	2	3	4	5	Have no aches and pains
7.	Low energy level	1	2	3	4	5	Full of pep and energy
8.	Often stiff in the morning	1	2	3	4	5	Never stiff in the morning
9.	Often restless or agitated	1	2	3	4	5	Feel relaxed
10.	Often do not feel good	1	2	3	4	5	Feel good

Brief Fatigue Inventory

Today's date:

Throughout our lives, most of us have times when we feel very tired or fatigued. Have you felt unusually tired or fatigued in the last week?

☐ YES or ☐ NO

1. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your fatigue right NOW.

0 1 2 3 4 5 6 7 8 9 10
No Fatigue — As bad as you can imagine

2. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your USUAL level of fatigue during the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Fatigue — As bad as you can imagine

3. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your WORST level of fatigue during the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Fatigue — As bad as you can imagine

4. Circle the one number that describes how, during the past 24 hours, fatigue has interfered with your:

A. GENERAL ACTIVITY

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

B. MOOD

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

C. WALKING ABILITY

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

D. NORMAL WORK (includes both work outside the home and daily chores)

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

E. RELATIONS WITH OTHER PEOPLE

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

F. ENJOYMENT OF LIFE

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

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MEDICAL CLEARANCE FORM

Today's date:

Dear Doctor _____,

_____ would like to begin an exercise program at the Sanford Springvale YMCA. This is a program designed for adult cancer patients/survivors who have recently become deconditioned or chronically fatigued from their treatment and/or disease. The program includes cardio respiratory, muscular strength, endurance and flexibility activities. A specific individualized exercise program will be created for the participant based on the needs, interests, and any recommendations you might have. This program is designed to start easy and gradually increase the workload on the body over a period of time in order to improve overall fitness and muscular strength. Exercise programs will be administered and monitored on a one to one basis and/or in small groups of twelve or less by a certified fitness instructor.

However, by completing the form below you are not assuming any responsibility for our administration of the exercise program.

☐ I know of no reason why the applicant may not participate

☐ I believe the applicant can participate, but I urge caution because:

☐ The applicant should not engage in the following activities:

☐ I recommend that this applicant NOT participate.

Physician Name (please print) Date:

Physician Signature Date:

Physician phone