

**ONCOLOGY EXERCISE PROGRAM** **REGISTRATION PACKET**

Thank you for your interest in the **Oncology Exercise Program** offered by Upper Valley Medical Center at the Miami County YMCAs. Enrollment is for classes offered twice per week for 6 weeks. Enclosed you will find a registration packet for your first **6-week session**.

**Description:** This program will provide you with an exercise program that is specific to your individual needs and abilities within a group setting. Classes are taught by a Certified Athletic Trainer certified as a Cancer Exercise Trainer through the American College of Sports Medicine. Prior to the first class, you will meet with our instructor for an individual fitness assessment to individualize the program for the best possible outcomes.

**Time: Mondays and Wednesdays from 1:00-2:00 pm**.

**Location: Piqua Branch Miami County YMCA**

 **223 W. High St**

 **Piqua, OH**

**Class Structure:** We will focus on low to moderate intensity exercise at your own pace. Each class consists of a mixture of cardiovascular exercise and strength training using a variety of equipment. The goal of this program is to help individuals perform an exercise program that they can do on their own to help:

* Improve cardiovascular function
* Increase muscular strength and endurance
* Battle cancer related fatigue and reduce side effects of the disease process
* Decrease symptoms of anxiety and depression in patients during and after treatments
* Increase quality of life regardless of stage of cancer

**Registration Checklist:**

**\_\_\_** Have your physician, oncologist, or surgeon complete the Physician Consent Form**.** This form can be faxed directly to (937) 667-4038 by the physician’s office. **This is the step that secures your spot in the class.**

**\_\_\_** Complete the additional paperwork packet included. Please bring this completed paperwork to your assessment appointment with our instructor.

**Once we receive the Physician Consent Form, you will be contacted to set up your assessment appointment and registration for the next session. During this appointment, we will review your paperwork and complete a basic fitness test. For questions or more information, please contact our instructor, Jonny Nemeth, at 614-370-3204.**



**DEMOGRAPHIC INFORMATION**

DATE \_\_\_\_\_\_\_\_\_ NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (LAST) (FIRST) (MI)

GENDER \_\_\_\_ MALE \_\_\_\_\_\_ FEMALE BIRTH DATE \_\_\_/\_\_\_\_/\_\_\_\_

STREET ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE \_\_\_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_

WORK PHONE (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ CELL PHONE NUMBER (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_

EMERGENCY CONTACT:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER HOME/ CELL (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ WORK (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_

**PHYSICIAN INFORMATION**

REFERRING PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SURGEON \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL ONCOLOGIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RADIATION ONCOLOGIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other physicians taking care of you? (Ex. Surgeon, Cardiologist, Pulmonologist)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SPECIALITY \_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SPECIALITY \_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you were in the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_ MONTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR

How many days were you in the hospital last time? \_\_\_\_\_\_\_\_\_\_\_\_ DAYS

Why were you in the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ONCOLOGY EXERCISE PROGRAM**

**Cancer History**

|  |  |  |
| --- | --- | --- |
| **Cancer type** | **Type of treatment (check all that apply)** | **Are you currently receiving this treatment?** |
| **Chemo** | **Radiation** | **Surgery** | **Targeted** | **No (Date since last treatment)** | **Yes** |
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PRESCRIPTION MEDICATIONS/VITAMINS/SUPPLEMENTS

List all **prescriptions, medications, vitamins, over the counter medication, remedies and supplements** you currently use

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of drug** | **Dose**  | **Times per day** | **Reason for taking** |
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Do any of your medications cause side effects that may affect your ability to exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ONCOLOGY EXERCISE PROGRAM**

**1. Are you currently suffering from any of the orthopedic problems listed below:** (\*Please be specific- Ex. **Right** knee or **Left** shoulder or **Both** hips)

\_\_\_\_\_\_\_\_\_\_\_ Back \_\_\_\_\_\_\_\_\_\_\_ Hip \_\_\_\_\_\_\_\_\_\_\_ Knee \_\_\_\_\_\_\_\_\_\_\_ Ankle \_\_\_\_\_\_\_\_\_\_\_ Feet

\_\_\_\_\_\_\_\_\_\_\_ Neck \_\_\_\_\_\_\_\_\_\_\_ Shoulder \_\_\_\_\_\_\_\_\_\_\_ Arms \_\_\_\_\_\_\_\_\_\_\_ Hands

**2. Have you had orthopedic surgeries within the last 5 years? Please list below:**

Body part (Left/Right/Both) Surgery Month/Year

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** **Have you been diagnosed with any of the following conditions?**

\_\_\_\_ Anxiety \_\_\_\_ Asthma \_\_\_\_ Circulation Problems \_\_\_\_ Depression

\_\_\_\_ Diabetes \_\_\_\_ Fibromyalgia \_\_\_\_ Heart Condition \_\_\_\_ High Blood Pressure

\_\_\_\_ High Cholesterol \_\_\_\_ Lymphedema \_\_\_\_ Numbness in hands or feet

\_\_\_\_ Osteoporosis/Osteopenia \_\_\_\_ Thyroid problems

**4. Do you currently have any trouble doing any of the following daily activities?**

\_\_\_\_ Walking for extended period. Please estimate distance or time you can walk \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Getting in/ out of chair \_\_\_\_ Getting up/down stairs

\_\_\_\_ Picking up and carrying items \_\_\_\_ Doing household activities

**5. Are you on a current exercise program: Please circle YES or NO**

Please describe your current exercise program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often (Ex. 2-3 days a week)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do you participate in your current exercise program (Ex. 30-40 min)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been on this exercise routine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **ONCOLOGY EXERCISE PROGRAM**

Do you have any allergies or sensitivities? \_\_\_\_\_ YES \_\_\_\_\_\_ NO

If yes, please list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any reactions after handling any rubber products such as Band-Aids, rubber balls, rubber bands, or balloons? \_\_\_\_\_ YES \_\_\_\_\_ NO

Have you been told you are anemic? \_\_\_\_ YES \_\_\_\_ NO

Have you ever had a transfusion with red blood cells? \_\_\_\_ YES \_\_\_\_ NO

If yes, when was your last transfusion with red blood cells? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year

Do you currently use any assistance devices?

\_\_\_\_ Wheelchair \_\_\_\_ Walker \_\_\_\_ Cane \_\_\_\_ Scooter \_\_\_\_ Crutches

Do you have difficulty hearing? \_\_\_\_ YES \_\_\_\_ NO If yes, hearing aids used? \_\_\_\_ YES \_\_\_\_ NO

Do you have any visual problems? \_\_\_\_ YES \_\_\_\_ NO If yes, vision aids used: \_\_\_\_\_\_\_ Glasses \_\_\_\_\_ Contact Lenses

**Immunization History**

Have you received an influenza shot within the last year? \_\_\_\_ YES \_\_\_\_ NO Date of last shot \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Have you received a Pneumonia shot within the last year? \_\_\_\_ YES \_\_\_\_ NO Date of last shot \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

If over the age of 60, have you received a shingles vaccination \_\_\_\_ YES \_\_\_\_ NO Date of last shot \_\_\_/\_\_\_\_/\_\_\_

**Pain**

Are you currently experiencing pain on a daily basis? \_\_\_\_ YES \_\_\_\_ NO

If **NO**, please go to the next page. If **YES**, please complete the following for each site of pain:

1. I have pain in my \_\_\_\_\_\_\_\_\_\_\_\_\_\_, with “0” being no pain and “10” being the most unbearable pain you could imagine, the best pain in this last week has been \_\_\_\_\_ out of 10 and the worst pain has been \_\_\_\_ out of 10.
2. I have pain in my \_\_\_\_\_\_\_\_\_\_\_\_\_\_, with “0” being no pain and “10” being the most unbearable pain you could imagine, the best pain in this last week has been \_\_\_\_\_ out of 10 and the worst pain has been \_\_\_\_ out of 10.
3. I have pain in my \_\_\_\_\_\_\_\_\_\_\_\_\_\_, with “0” being no pain and “10” being the most unbearable pain you could imagine, the best pain in this last week has been \_\_\_\_\_ out of 10 and the worst pain has been \_\_\_\_ out of 10.
4. I have pain in my \_\_\_\_\_\_\_\_\_\_\_\_\_\_, with “0” being no pain and “10” being the most unbearable pain you could imagine, the best pain in this last week has been \_\_\_\_\_ out of 10 and the worst pain has been \_\_\_\_ out of 10.

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 **ONCOLOGY EXERCISE PROGRAM**

**CURRENT SYMPTOMS:** Indicate any symptoms you are currently experiencing, rating the frequency and severity, according to the following:

**Frequency:** 1=never 2= less than once a month 3= about once a week

4-= more than once a week 5= daily/ nearly daily

**Severity:**  0= never 10= extreme

|  |  |  |
| --- | --- | --- |
| **Symptoms** | **Frequency (1-5)** | **Severity (0-10)** |
| Chest pain/pressure/tightness |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Shortness of breath |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Wheezing |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Dizziness or feeling faint |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Black out spells |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Feet/ankle swelling |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Palpitations/heart fluttering |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Shoulder pain (Right/Left) |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Knee pain (Right/Left) |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Hip pain (Right/Left) |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Low back pain |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Neck pain |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Foot/ankle pain (Right/Left) |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Other bone or join pain |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Frequent indigestion |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |
| Sleeping difficulties |  1 2 3 4 5 |  0 1 2 3 4 5 6 7 8 9 10 |

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**Oncology Exercise Program End of Program Evaluation**

**To help us serve you and future participants better, please complete the following questionnaire**

**Overall program**

**1**= Strongly Disagree  **2**= Somewhat Disagree **3**= neutral **4**= Agree  **5**= Strongly Agree

1. The enrollment process to the Upper Valley Medical Center  **1 2 3 4 5**  Oncology Exercise Program was efficient and easy.
2. The initial and post assessments were informative, helpful and  **1 2 3 4 5**  allowed questions to be answered.
3. I felt that the Oncology Exercise Program guided a safe and **1 2 3 4 5** effective exercise program.
4. The Cancer Exercise Trainer was prepared and **1 2 3 4 5** knowledgeable for all the exercise sessions.
5. The Oncology Exercise plan was monitored and updated by a **1 2 3 4**  **5** Cancer Exercise Trainer throughout the program.
6. What did you like best about the Oncology Exercise Program?
7. What did you like the least about the Oncology Exercise Program?
8. Do you have any suggestions for improvement?