THRIVE Intake Form and Health Screening Questionnaire

Name_______________________________________ Today's date (MM/DD/YYYY): ____________________

Date of Birth (MM/DD/YYYY): ____________________ Age: ______

Preferred phone: ________________________(home/cell) Alternate phone: ____________________(home/cell)

Email: ____

Emergency Contact

Name: ____ Relationship: ________________________

Preferred phone: ________________________(home/cell) Alternate phone: ____________________(home/cell)

Physician Info

Primary physician: _______________________________________ (______) _____________________

Other physicians involved in your treatment/care: (use reverse side if necessary)

Name	Specialty	Phone number
____________________________	__________________________	(_______) ____________________
____________________________	__________________________	(_______) ____________________
____________________________	__________________________	(_______) ____________________

How did you learn about the THRIVE program? ____

Medical History – General

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 treatment)	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:

____

____

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

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____

____

Medical History - Cancer Diagnosis and Treatment: please respond specifically to all that apply

What was the date of your cancer diagnosis (MM/YYYY)? ____________________________________

What type of cancer were you diagnosed with (eg. breast, lung, prostate, etc)? ________________________________

What stage was your cancer? 0 I II III IV Undetermined Don't know

What types of cancer treatments have you received or will you receive in the future?

Surgery

No Current Completed: date (MM/YY): ___/___ Future/planned: date (MM/YY): ___/___

Type of surgery (if known)____

Chemotherapy

No Current Completed: date (MM/YY): ___/___ Future/planned: date (MM/YY): ___/___

Date of last treatment:__________________________

Treatment schedule: ____

Radiation

No Current Completed: date (MM/YY): ___/___ Future/planned: date (MM/YY): ___/___

Location _______________________ Date of last treatment:__________________________

Treatment schedule: ____

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

Yes (location__________________) No

Are you experiencing any numbness, tingling, or weakness? Yes No

If yes, please describe where ____

Has the cancer spread to your bones? Yes No Don't know

If yes, please describe where ____

Have you had any Lymph Nodes removed? Yes No Don't know

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 with 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

Is there anything else about your cancer or your cancer treatments you'd like us to know that we haven't asked yet?

____

____

____

Medications/Lifestyle/Other:

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

____

____

____

Describe your health at the present time: Excellent Good Fair Poor

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?

No Yes If yes, please explain

____

____

Are you currently 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?

____

____

____

Are you currently following any specific diet plan or weight loss program? If so, please list all that apply.

____

____

____

What, if any, weight management or weight loss program/s have you tried in the past?

____

____

____

Who in your household is responsible for food shopping and food preparation?

____

____

____

How many meals/snacks per week are eaten outside the home?

____
____
____

Do you have any concerns about changing your food choices and eating behaviors?

____
____
____

Are you willing to commit to precisely tracking your exercise and food intake through the use of a journal or log for the duration of the program?

____
____
____

How will you determine your personal success/satisfaction with this program?

____
____
____

What expectations do you have from this program?

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____
____

How will you determine personal success/satisfaction with this program?

____
____
____

What is your preferred class time? Please number them from 1 to 3 with 1 being your first choice. If a class time is impossible for you to make, please leave it blank.

____ Monday AND Wednesday 12:00 – 1:00 p.m.
____ Tuesday AND Thursday 9:00 – 10:00 a.m.
____ Tuesday AND Thursday 5:30 – 6:30 p.m.

For Staff Use/General Notes: T-SHIRT SIZE: S M L XL XXL